S. No. 2
0M—2-43
v. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 7 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13309

Registration District No. 141 | Primary Registration District No. 3025 | Registrar's No. 60

1. PLACE OF DEATH:

(a) County: Howell

(b) City or town: West Plains
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: No. (Specify whether
In this community: 53 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Howell 46

(c) City or town: West Plains
(If outside city or town limits, write "RURAL")

(d) Street No.: 543 Missouri Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: HENRY OLIVER CALHOON

3. (b) If veteran, name war: ---

3. (c) Social Security No.: ---

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, divorced: widowed

6. (b) Name of husband or wife: Mary A. Calhoon

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Feb. (Month) 2, (Day) 1864 (Year)

8. AGE: Years 83 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace: Obion County, (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: August M. Calhoon
13. Birthplace: unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Raymond Calhoon,
(b) Address: St. Louis, Mo.

17. (a) Burial, Cremation, Removal: Oak Lawn Cem. (b) Date thereof: Apr. 13, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: West Plains, Mo.

18. (a) Signature of funeral director: Hal Thanburgh
(b) Address: West Plains, Mo.

19. (a) April 21-47 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10, year 1947 hour 7: minute 45 a.m.

21. I hereby certify that I attended the deceased from 1/28, 1947 to 3/18, 1947; that I last saw him alive on 3/18, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Heart Disease — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature: [illegible] (M.D. or other)
Address: West Plains, Missouri Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 547252
Date Filed 5-6-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by S. L. Duncan, Registered Apprentice No. 390, working under my personal supervision.

Signed Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.