

No. 2
12-45
17-39
47070

FILED JUL 9 1947

Registration District No. 327

Primary Registration District No. 6139

Registrar's No. 67

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Shelbyville - Rural
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) /
(d) Length of stay: In hospital or institution 57 year (Specify whether years, months or days)

3. (a) PRINT FULL NAME IDA CALVERT
3. (b) If veteran, name war ✓ 3. (c) Social Security No. 2

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Jim Calvert Dead 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan. 4 - 1869
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 23 If less than one day ✓ hr. ✓ min.

9. Birthplace Macon G. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Jamie Henry Farmer

13. Birthplace Va. (City, town, or county) (State or foreign country)

14. Maiden name Margaret Ann Armstrong

15. Birthplace Penn. (City, town, or county) (State or foreign country)

16. (a) Informant Chas. Calvert

(b) Address Emden Mo

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof May 31 - 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Emden Cemetery

18. (a) Signature of funeral director E.P. Thompson

(b) Address Shelbyville Mo

19. (a) July 4 - 47 (Date received) (b) Greth Jones (Registrar's signature) (c) 217 (Date received by registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shelby 102
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 27 year 1947 hour 9:30 minute 10 M.
21. I hereby certify that I attended the deceased from May 1 1947 to May 27 1947 that I last saw her alive on May 27 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia Duration 3 day

Due to Influenza & Fractured Shoulder

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 7. 8. 6. 7. 10 Of autopsy

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?

While at work? (Specify type of place) (2) Means of injury 2

23. Signature E.P. Thompson (M. D. or other) 00
Address Shelbyville Mo Date signed 6-3-47

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

MOTHER FATHER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 102

JUL 26 1956

RECEIVED
District Health Officer No. 10
District File Number 7-47-852
Date Filed JUL - 7 1947

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.....

.....*Myself*....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*E. P. Thompson*.....

Licensed Embalmer No. *1632*

P. O. Address.....*Shelbyville 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.