

FILED SEP 13 1948

318

1003

7706

Registration District No.

Primary Registration District No.

Registrar's No.

## 1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... **St Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:..... **Homer G Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 days** (Specify whether  
In this community..... **25 yrs** years, months or days)

3. (a) PRINT  
FULL NAME**Andrew Calhoun**

3. (b) If veteran,  
name war..... **No**

3. (c) Social Security No.  
**Unk**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married,  
divorced **Married**  
6. (b) Name of husband or wife..... **Luanna Calhoun** 6. (c) Age of husband or wife if  
alive **36** years  
7. Birth date of deceased **August 13 1901**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**47 0 15** hr. min.

9. Birthplace..... **Mississippi**  
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Laborer**

## 11. Industry or business

MOTHER FATHER { 12. Name..... **Joe Calhoun**  
13. Birthplace..... **Mississippi**  
(City, town, or county) (State or foreign country)  
14. Maiden name..... **Unknown**  
15. Birthplace..... **Mississippi**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Luanna Calhoun**  
(b) Address..... **103 N. Channing**

17. (a) **Burial** (b) Date thereof **9-2-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation..... **St. Louis**

18. (a) Signature of funeral director..... **J. F. Bradach**  
(b) Address..... **3517 Laclede Ave.**

19. (a) **SEP 1 1948** (Date received local registrar)  
**J. F. Bradach** (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County..... **St Louis**  
(c) City or town..... **103 Channing**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **21** (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **28**  
year..... **1948** hour..... **11** minute..... **40** A.M.

21. I hereby certify that I attended the deceased from.....  
**August 23,** 19**48**, to **August 28,** 19**48**;  
that I last saw him alive on..... **August 28,** 19**48**;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Generalized Peritonitis**  
**Prob Ruptured Duodenal Ulcer**

Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
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?

(Specify type of place)  
While at work?..... Means of injury.....  
23. Signature..... **C. R. Frozer** (M. D. or D. O.)  
Address..... **2601 N Whittier** Date signed..... **8-30-48**

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

Signed.....

*Melvin E. Green*

Licensed Embalmer No. *4428*

P. O. Address *St. Louis, 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.**