

STANDARD CERTIFICATE OF DEATH

State File No. **21213**
5968

FILED JUL 15 1949

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY ado			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis O		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17		d. STREET ADDRESS (If rural, give location) 21-3032 Bell Avenue 10	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 21-3032 Bell Avenue			
3. NAME OF DECEASED (Type or Print)		a. (First) Calvin		b. (Middle) _____		c. (Last) James	
5. SEX male 2		6. COLOR OR RACE col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH March 10 1900	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moving Van		10b. KIND OF BUSINESS OR INDUSTRY Moving		9. AGE (In years last birthday) 49		11. BIRTHPLACE (State or foreign country) Ark	
13a. FATHER'S NAME Samuel W. James		13b. MOTHER'S MAIDEN NAME Judy Bell		14. NAME OF HUSBAND OR WIFE widow		12. CITIZEN OF WHAT COUNTRY? _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. #1 489-16-5088		17. INFORMANT'S SIGNATURE OR NAME Milton Duncan		ADDRESS 3032 Bell Avenue	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis Pulmonary Tuberculosis and Tuberculous			
				INTERVAL BETWEEN ONSET AND DEATH _____			
2. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) _____							
3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? 002X			
22. I hereby certify that I attended the deceased from 6-30 , 19 49 , to 7-5 , 19 49 , that I last saw the deceased alive on 7-5 , 19 49 , and that death occurred at 10:45p m. , from the causes and on the date stated above.							
23a. SIGNATURE James Hedrick (Degree or title) M. D. O				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 7-7-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7-11-1949		24c. NAME OF CEMETERY OR CREMATORY Natl Jefferson Brks		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.	
DATE REC'D BY LOCAL REG. JUL 7 1949		REGISTRAR'S SIGNATURE J. H. Randle		25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son ADDRESS 3133 Bell Ave			

(Licensed Embalmer's Statement on Reverse Side)

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

Name

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 _____

Student Embalmer No. _____

Working under my personal supervision.

Student

Student Embalmer

Signed _____

Licensed Embalmer No. *247A*

P. O. Address *2764 Chilton*

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.