

FILED NOV 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34526

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6072 Registrar's No. 347

1. PLACE OF DEATH a. COUNTY ST. FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. FRANCOIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL PENDELTON TWP.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL PENDELTON TWP.	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROUTE 1 ELVINS		d. STREET ADDRESS (If rural, give location) R.I. ELVINS Mo. 0940	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) WALLACE	c. (Last) CALVERT	4. DATE OF DEATH (Month) (Day) (Year) OCT. 22 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 8, 1858	9. AGE (In years) (Month) (Day) 92 5 14	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WORKER	10b. KIND OF BUSINESS OR INDUSTRY ST. JOSEPH LEAD	11. BIRTHPLACE (State or foreign country) WASHINGTON Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LEVI SCOTT CALVERT	13b. MOTHER'S MAIDEN NAME MARTHA SCOTT	14. NAME OF HUSBAND OR WIFE DORA RILEY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME LUCY SNODELL	ADDRESS ELVINS Mo. R.I.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyperstatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) arteriosclerosis, nephritis the underlying cause last.		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			442X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept 1950**, to **Oct 22 1950**, that I last saw the deceased alive on **Oct 16 1950**, and that death occurred at **10:15 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. M. Stanfield M.D.	23b. ADDRESS Harmon Station No 10940	23c. DATE SIGNED 10/24/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT. 25 1950	24c. NAME OF CEMETERY OR CREMATORY BONNE TERRE	24d. LOCATION (City, town, or county) (State) BONNE TERRE Mo.
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DATE REC'D BY LOCAL REG. Oct 25 1950	REGISTRAR'S SIGNATURE Ether Rudolph	25. FUNERAL DIRECTOR'S SIGNATURE Benjamin Hudlo	ADDRESS Bonne Terre Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

940

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 30 1950

RECEIVED

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Clarence J. Graywell

Licensed Embalmer No. *3706*

P. O. Address *Boxed June 9th*

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.