

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42601**
Registrar's No. **313**

FILED JAN 8 1952

BIRTH NO. _____ REG. DIST. NO. **294** PRIMARY REG. DIST. NO. **4439**

1. PLACE OF DEATH a. COUNTY RANDOLPH		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MISSOURI b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLARK		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLARK	
c. LENGTH OF STAY (in this place) 3 mo.		d. STREET ADDRESS (If rural, give location) DR 80	
d. FULL NAME OF HOSPITAL OR INSTITUTION L			

3. NAME OF DECEASED (Type or Print) a. (First) LAYENA b. (Middle) ALICE c. (Last) CALBERT			4. DATE OF DEATH (Month) (Day) (Year) DEC. 29-1951		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 7-1879	9. AGE (In years last birthday) 72	10 UNDER 1 YEAR 1	10 UNDER 1 WEEK 21
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.F.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BOONE Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ISAAC DAVIS	13b. MOTHER'S MAIDEN NAME JOHANNA ALSPACH	14. NAME OF HUSBAND OR WIFE H.C. Calvert
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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) L	16. SOCIAL SECURITY NO. L	17. INFORMANT'S SIGNATURE OR NAME Mrs Roy R. Green ADDRESS Centralia Mo
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) 4222
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **12-27-51**, 19___, to **12-29-51**, 19___, that I last saw the deceased alive on **12-28-51**, 19___, and that death occurred at **3:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E.T. Whitaker M.D.	23b. ADDRESS Independence, Mo.	23c. DATE SIGNED 12-30-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE DEC. 31-1951	24c. NAME OF CEMETERY OR CREMATORY CHAPEL GROVE	24d. LOCATION (City, town, or county) (State) CLARK - Mo.
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DATE REC'D BY LOCAL REG. Dec 31-51	REGISTRAR'S SIGNATURE Leah Beaman Lowe	25. FUNERAL DIRECTOR'S SIGNATURE Barnes & Booth Sturgeon-Mo. ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1939

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.

Student Embalmer No.....

Signed.....

A. E. Boothe

Signed.....
Student Embalmer

Licensed Embalmer No. 4087

P. O. Address. Sturgis - 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.