

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36234**

BIRTH NO. **71477** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9908**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MO.</b>		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		2219	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. MARY INFIRMARY</b>			d. STREET ADDRESS (If rural, give location) <b>2826 CASS AVE</b>			
3. NAME OF DECEASED (Type or Print) <b>JOHN GABLE CALHOUN</b> a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>10-27-52</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COL.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>9-29-52</b>	9. AGE (In years last birthday)	9. AGE (In years last birthday) If under 1 year: Months Days If under 24 hrs: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>WILLIE G. CALHOUN</b>		13b. MOTHER'S MAIDEN NAME <b>WILLIE B. HALL</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Intestinal Obstruction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9/29/52</b>			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused 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. <b>Peritonitis</b>						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Adhesions Large bowel (Congenital)</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)		7562	
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?				
22. I hereby certify that I attended the deceased from <b>10/27, 1952</b> , to <b>10/27, 1952</b> , that I last saw the deceased alive on <b>10/27, 1952</b> , and that death occurred at <b>109 m.</b> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <b>William H. Pugh, M.D.</b>			23b. ADDRESS <b>4503 Page</b>		23c. DATE SIGNED <b>10/28/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>4 Oct 28-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Green Wood</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, MO</b>			
DATE REC'D BY LOCAL REG. <b>OCT 28 1952</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Walker</b>		ADDRESS <b>2700 THOMAS</b>	

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

*Not Embalmed*

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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 *P. Watkins* \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.