

5. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22336**

FILED JUL 13 1953

BIRTH NO. _____ REG. DIST. NO. **254** PRIMARY REG. DIST. NO. **4386** Registrar's No. **24**

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) Thayer		c. CITY (If outside corporate limits, write RURAL and give township) Thayer	
c. LENGTH OF STAY (in this place) 49 yrs		d. STREET ADDRESS (If rural, give location) 0731	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS	

3. NAME OF DECEASED a. (First) SERBINA (Type or Print)		b. (Middle)		c. (Last) CALVIN		4. DATE OF DEATH (Month) (Day) (Year) June 12, 1953	
---	--	-------------	--	-------------------------	--	--	--

5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Feb. 13, 1861		9. AGE (In years last birthday) Months Days 92		10. IF UNDER 1 YEAR Hours Min.	
----------------------	--	-------------------------------	--	--	--	--	--	--	--	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Texas Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
---	--	-----------------------------------	--	---	--	---	--

13a. FATHER'S NAME Joe Williams		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Grant Calvin, dec.	
---	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. J. W. Jewell		ADDRESS Thayer, Mo.	
---	--	-------------------------	--	---	--	-------------------------------	--

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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) My condition due to Scurvy		MEDICAL CERTIFICATION		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) Renal Insufficiency			
		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 4222		20. AUTOPSY? YES <input 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)	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:35 P m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		(Degree or title) M. D. O.		23b. ADDRESS Thayer		23c. DATE SIGNED 7-3-53	
--------------------------------------	--	-----------------------------------	--	-------------------------------	--	-----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/14/53		24c. NAME OF CEMETERY OR CREMATORY Norman Cemetery		24d. LOCATION (City, town, or county) (State)	
--	--	-----------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. 7-6-53		REGISTRAR'S SIGNATURE Arthur Wolff		25. FUNERAL DIRECTOR'S SIGNATURE Richard Carter		ADDRESS Thayer, Mo.	
---	--	--	--	---	--	-------------------------------	--

(Licensed Embalmer's Statement on Reverse Side)

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

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

[Handwritten Signature]

Licensed Embalmer No. *4516*

P. O. Address

[Handwritten 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.