

FILED FEB 2 - 1955

THE DIVISION OF HEALTH OF INDIANA  
STANDARD CERTIFICATE OF DEATH

State File No. ....

2402

0141

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....			
1. PLACE OF DEATH a. COUNTY <b>0</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Indiana</b> b. COUNTY <b>Sullivan</b>					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>Farmersburg</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BARNES HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>8130g</b>					
3. NAME OF DECEASED (Type or Print)		a. (First) <b>FLOYD</b>		b. (Middle) <b>NMN</b>		c. (Last) <b>CALVIN</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 5 1955</b>			
8. DATE OF BIRTH <b>Nov. 20, 1907</b>		9. AGE (in years last birthday) <b>47</b>		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) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barbering</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Hume, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Frank Calvin</b>			13b. MOTHER'S MAIDEN NAME <b>Nora Hayes</b>			14. NAME OF HUSBAND OR WIFE <b>Mary Calvin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mary Calvin, Farmersburg, Indiana</b>		ADDRESS _____			
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain tumor, olfactory groove meningoma, right</b> ANTECEDENT CAUSES <b>meningoma, right</b> 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.				INTERVAL BETWEEN ONSET AND DEATH <b>sev. years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>223'x</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <b>Dec. 30, 1954</b> , to <b>Jan. 5, 1955</b> , that I last saw the deceased alive on <b>Jan. 5, 1955</b> , and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>C. D. Venable, M.D.</b> (Degree or title) <b>M. D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>1-5-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-6-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Farmersburg, Indiana</b>			
DATE REC'D BY LOCAL REG. <b>JAN 6 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>		ADDRESS <b>4700 Washington.</b>			

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

HEB 8

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.....  
Signature of Student Embalmer

Signed *W. W. Wilkerson*

Licensed Embalmer No. 357

P. O. Address *W. Lou*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.