

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27189

State File No. ....

*804*

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 5923 Registrar's No. 223

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>Rural Cedar 3 yrs.</u>	c. CITY OR TOWN <u>Sedalia,</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Buena Vista Home</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No. <u>0900</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>H.</u> c. (Last) <u>CALVIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 24, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 12, 1876</u>
9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work or business, nature of working life, even if retired) <u>mechanist R.R. shops</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ret'd.</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>Portland, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Hiram Calvin</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Neff</u>	14. NAME OF HUSBAND OR WIFE <u>Rachel B. Calvin</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME, 4th ADDRESS <u>Mrs. Nora Martin, 90 W. Sedalia, Mo.</u>
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) <u>CORONARY OCCLUSION.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS.</u> 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 <u>4201</u>	
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) 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 <u>JUNE</u> , 19 <u>55</u> , to <u>AUG 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 AUG. 1950</u> , and that death occurred at <u>8: P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Karl B. Jones MD</u> (Degree or title)		23b. ADDRESS <u>SEDALIA, MO</u>	23c. DATE SIGNED <u>26 AUG 55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>
DATE REC'D BY LOCAL REG. <u>8/27/55</u>	REGISTRAR'S SIGNATURE <u>Lovena Coontz Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>251 Duane Ewing</u>	ADDRESS <u>Sedalia, Mo.</u>

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

Dr. Gonser

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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.....  
Signature of Student Embalmer

Signed *Ruane Ewing*.....

Licensed Embalmer No. *2211*

P. O. Address *Sedalia*.....

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.