

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34635**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9139**

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY - - -	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 2 Mo.	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hospital		e. STREET ADDRESS (If rural, give location) 4224 Olive St.	
3. NAME OF DECEASED (Type or Print) a. (First) Lon b. (Middle) Joseph C c. (Last) Calmer		4. DATE OF DEATH (Month) (Day) (Year) 10 18 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 3/24/1893
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Edward J. Calmer	13b. MOTHER'S MAIDEN NAME Julia Long	14. NAME OF HUSBAND OR WIFE - - -
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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) Yes W.W.#1	16. SOCIAL SECURITY NO. 703-03-3333	17. INFORMANT'S SIGNATURE OR NAME Marion Calmer	ADDRESS MO. 4066 Lindell St. Louis
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE NECROTIC PANCREATITIS		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Chronic Cholecystitis operated (Cholecystectomy)		
	DUE TO (c) Psychosis WOUND DISRUPTION		
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 Cholecystitis, Chr.; wound disruption	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 585x
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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 **8/19**, 19**55**, to **10/18**, 19**55**, that I last saw the deceased alive on **10/18**, 19**55**, and that death occurred at **11:50a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Baron Passanante, M.D.	23b. ADDRESS 462 N Taylor	23c. DATE SIGNED 10-20-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/21/1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. OCT 20 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.
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E.P. (Licensed Embalmer's Statement on Reverse Side)

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

