# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59–033322
STATE FILE NUMBER

ENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 110

1. PLACE OF DEATH
a. COUNTY: PIKE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: LOUISIANA
Length of stay in 1b: LIFE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 615 N. CAROLINA
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: PIKE
c. CITY OR TOWN: LOUISIANA
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 615 N. CAROLINA
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First GEORGE Middle WAYNE Last CALVIN
4. DATE OF DEATH: Month SEPT Day 5 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: AUG 5 1949
9. AGE (last birthday): 10
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: CHILD
11. BIRTHPLACE (City and state or country): LOUISIANA, MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: OTIS CLEMET CALVIN
13b. MOTHER'S MAIDEN NAME: ANNA MAE LAMBERSON
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: O.C. CALVIN
Address: LOUISIANA, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Palsy.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1953, to 1959 and last saw ~~her~~ him alive on July 8 1959
Death occurred at 6:15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. P. Hansen, DO.
22b. ADDRESS: Frankford Mo
22c. DATE SIGNED: 9/7/1959

BY AFFIDAVIT OF

22e. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: SEPT. 7, 1959
23c. NAME OF CEMETERY OR CREMATORY: RIVERVIEW CEM.
23d. LOCATION (City, town, or county) (State): LOUISIANA, MO.
24. FUNERAL DIRECTOR: GEO. M. COLLIER
ADDRESS: LOUISIANA, MO.
25. DATE RECD. BY LOCAL REG.: Sept 10-59
26. REGISTRAR'S SIGNATURE: Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Geo. M. Collier

Signature of Student Embalmer

Licensed Embalmer No. 3831

P. O. Address Louisia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.