

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028011

FILED VS. JUL 20 1960

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 277

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		c. CITY OR TOWN <b>Bonne Terre</b>	
Length of stay in 1b <b>1 hour</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>RR# 2</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Ann</b> Last <b>Calvert</b>			4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 16, 1877</b>
9. AGE (last birthday) <b>83</b>		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) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St Marys Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>US</b>		13a. FATHER'S NAME <b>George Brewster</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Brown</b>		14. NAME OF HUSBAND OR WIFE <b>David B Calvert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs S. A. Newcomer, Bonne Terre, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Atherosclerotic heart disease</b> DUE TO (c) <b>Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1-hour</b> <b>?</b> <b>1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <b>7-9-60</b> to <b>7-9-60</b> and last saw her alive on <b>7-9-60</b> Death occurred at <b>9:05 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <b>Paul W. Taylor M.D.</b>		21b. ADDRESS <b>Bonne Terre, Mo</b>	
21c. DATE SIGNED <b>7-11-60</b>		21d. ADDRESS (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 12, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bonne Terre</b>	23d. LOCATION (City, town, or county) <b>Bonne Terre, Mo.</b>
24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son, Bonne Terre, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>July 12, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 36

P. O. Address Albany

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.