

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5771

AMENDED  
FILED JUN 29 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>				Length of stay in 1b		c. CITY OR TOWN <u>Springfield</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis-Little Rock Hospitals, Inc.</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>509 1/2 W. Jefferson Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>Joseph</u> Last <u>Garhart</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-10-1890</u>		
						9. AGE (last birthday) <u>71</u>		
						IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pens. Conductor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Dayton, Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Carrie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.II</u>				17. INFORMANT <u>Carrie Garhart</u> Address <u>509 1/2 W. Jefferson Ave.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Encephalomalacia</u>						<u>6/10/61</u>		
DUE TO (b) <u>Cerebral thrombosis</u>						<u>6/10/61</u>		
DUE TO (c) <u>Arteriosclerosis</u> <u>332x</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ulcer of stomach</u> <u>Pulmonary emphysema</u> <u>Diabetes mell.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>6-16-61</u> to <u>6-19-61</u> and last saw him alive on <u>6-19-61</u>		Death occurred at <u>9.20 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Paul W. Harts M.D.</u>				22b. ADDRESS <u>1755 So. Grand</u>		22c. DATE SIGNED <u>6-20-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>6/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Camp Butler National Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Illinois</u>		
24. FUNERAL DIRECTOR <u>Bisch &amp; Son Funeral Home, Springfield, Ill.</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 20 1961</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>		

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John J. Hainen*

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.