

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029764

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318**

Primary Registration District **1003**

Registrar's No. **6985**

STATE FILE NUMBER

**FILED JUL 19 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b <b>2 1/2 YR.</b>	c. CITY OR TOWN <b>St Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2603 Spring</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ALPHONSE CALMES</b>			4. DATE OF DEATH Month <b>7</b> - Day <b>2</b> - Year <b>63</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>NCORO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1934</b>
9. AGE (last birthday) <b>29</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, etc. if retired) <b>SHIPPING CLERK.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Clothing</b>	11. BIRTHPLACE (City and state or country) <b>MACON MISS</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Wallace Calmes</b>	
13b. MOTHER'S MAIDEN NAME <b>Louise TUBRY</b>		14. NAME OF HUSBAND OR WIFE <b>Loretta Calmes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO NO</b>		17. INFORMANT Address <b>Loretta Calmes 2603 Spring</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion (Sclerosis)</b> DUE TO (b) <b>420.1</b> DUE TO (c) <b>420.1</b> 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. <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 _____ to _____ and last saw him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph M. Turner Deputy</b>		22b. ADDRESS <b>1300 Clair</b>	22c. DATE SIGNED <b>7-5-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-8-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) <b>Berkley</b>
24. FUNERAL DIRECTOR <b>PRICE FUNERAL Home 2829 Washington</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 5 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith. M.D.</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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Rev. 4/59  
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USE BLACK INK OR TYPEWRITER RIBBON

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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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Trinity ave

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.