

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12705**
Registrar's No. **15**

FILED MAY 5 - 1952

BIRTH NO. _____ REG. DIST. NO. **131** PRIMARY REG. DIST. NO. **3023**

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Henry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION CLINTON GENL HOSPT		d. STREET ADDRESS (If rural, give location) 705 S main St	
3. NAME OF DECEASED a. (First) WOODFORD b. (Middle) BECKETTE c. (Last) CALVIRT			4. DATE OF DEATH (Month) (Day) (Year) 4-27-1952
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8/20/1871
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST	11. BIRTHPLACE (State or foreign country) KAHOKA Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE LILLIAN CALVIRT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 0	
17. INFORMANT'S SIGNATURE OR NAME Mrs W. B. Calvert		ADDRESS Clinton Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 yrs ANTECEDENT CAUSES Chronic Nephritis DUE TO (b) _____ DUE TO (c) _____ 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 4200	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb , 19 47 , to 27 April , 19 52 , that I last saw the deceased live on 27 April, 1952 , and that death occurred at 11 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE James Smith M.D.		23b. ADDRESS Clinton Mo	
23c. DATE SIGNED 29 April 52		23d. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEM	
23e. LOCATION (City, town, or county) (State) Clinton Mo		23f. DATE 4/30/52	
23g. NAME OF CEMETERY OR CREMATORY EDGEWOOD CEM		23h. LOCATION (City, town, or county) (State) Clinton Mo	
23i. DATE REC'D BY LOCAL REG April-30-52		23j. REGISTRAR'S SIGNATURE Florence Adams	
23k. FUNERAL DIRECTOR'S SIGNATURE J. E. Consalus		23l. ADDRESS Clinton Mo	

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

APR 27 1953

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
Student Embalmer

Signed J E Consoer

Licensed Embalmer No. 1891

P. O. Address Clinton, Mo.

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 this body is not embalmed, fact should be so stated above.