DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17585

FILED JUN 13 1945

Registration District No. 3954 Primary Registration District No. 3046 Registrar's No. 247

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

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Latham's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Eight mile S of California
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Parks Calhoun
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Annie Laura Calhoun
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 2 (Day) 1864 (Year)

8. AGE: Years 81 Months 1 Days 6 If less than one day hr. min.

9. Birthplace Montgomery (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

MOTHER
12. Name John B Calhoun
13. Birthplace West Virginia state (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Jane Bynon
15. Birthplace England (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Wm Calhoun
(b) Address California Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation City Cem California Mo
18. (a) Signature of funeral director Williams & Friedmyer
(b) Address California Mo
19. (a) 5-10-45 (Date received local registrar) (b) B J Allee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1945 hour 6 minute 30 P.M.
21. I hereby certify that I attended the deceased from March 1, 1945 to May 8, 1945 that I last saw him alive on May 8, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	6 months
Due to: Generalized Arteriosclerosis	10 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Kenyon Latham (M. D. or other)
Address California, Mo Date signed 5-10-45

1312 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 6-12-45

MAR 28 1946

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Hugh E Williams

Licensed Embalmer No. 3537

P. O. Address California Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

L. No. 2B
5M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 324 Primary Registration District No. 30461 Registrar's No. 247

1. **PLACE OF DEATH:**
(a) County Montcau
(b) City or town California
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. **USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wm P. Calhoun

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive (Years)

7. Birth date of deceased April (Month) 2 (Day) 1865 (Year)

8. AGE: Years 81 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)
By D.H.A.

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

17585