

JUN 25 1927

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

14675

1. PLACE OF DEATH

County Dekalb Registration District No. 260  
Township Colfax Primary Registration District No. 5362  
City (No. ....) St. .... Ward

File No. ....  
Registered No. ....

2. FULL NAME George Winfield Caldwell

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Jane Caldwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9 24 1851

7. AGE YEARS MONTHS DAYS / If LESS than 1 day, .... hrs. or .... min.  
75 8 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....  
(STATE OR COUNTRY) Ky.

10. NAME OF FATHER Alexander Caldwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....  
(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Mary Jane Ditzler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....  
(STATE OR COUNTRY) Ind.

14. INFORMANT John Dite  
(Address) Weatherby Mo.

15. FILED 5-27 1927 Winifred W. Moser  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25<sup>th</sup> 1927

17. I HEREBY CERTIFY, That I attended deceased from death was attended, 19... in Dekalb, 19...  
that I last saw him alive on February, 1925, and that death occurred, on the date stated above, at 7 2 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

92H Sudden heart failure  
125B  
118C

(duration) .... yrs. .... mos. .... ds.  
CONTRIBUTORY Chronic disease of stomach  
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED at Lin Colm  
IF NOT AT PLACE OF DEATH, .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? history  
(Signed) John M. Brown, M. D.  
, 19 (Address) Maysville Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Amity. Cem Amity Mo. DATE OF BURIAL 5, 27 1927

20. UNDERTAKER U. G. Pilcher ADDRESS Maysville Mo

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County DeKalb Registration District No. 260 File No. ....  
 Township Colfax Primary Registration District No. 5362 Registered No. ....  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

Geo. Winfield Caldwell  
 (a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. 7-20-27 Winifred W. Moser REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1927

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... that I last saw him alive on 19... and that death occurred, on the date stated above at

THE CAUSE OF DEATH WAS AS FOLLOWS:

*SUPPLEMENTARY*  
Sudden heart failure  
critical  
valvular heart disease  
 (duration) ... yrs. ... mos. ... ds.  
chronic disease of  
myocardium  
 (duration) ... yrs. ... mos. ... ds.  
 18. WHERE WAS DISEASE CONTRACTED chronic passive  
 IF NOT AT PLACE OF DEATH portal congestion  
 DID AN OPERATION PRECEDE DEATH? No DATE OF ...  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) John M. Seel M. D.  
 , 19 July 11 1927 (Address) 826 1/2 St. Joseph Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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