

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

Do not use this space.

1442

**1. PLACE OF DEATH**  
 County Jackson Registration District No. 399  
 Township Kaw Primary Registration District No. 1002  
 City Kansas City, Mo (No. Trinity Lutheran Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME** Buford Francis Caldron  
 (a) Residence No. 4337 Madison St. 7 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 12 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single  
 (write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Sept 9, 1917  
**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
12 4 20

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work School Boy  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)** Kansas City, Mo  
 (STATE OR COUNTRY)

**10. NAME OF FATHER** Franklin L. Caldron  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Arkansas City, Kansas  
 (STATE OR COUNTRY)  
**12. MAIDEN NAME OF MOTHER** Edith A. Pierce  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** Illinois  
 (STATE OR COUNTRY)

**14. INFORMANT** F. L. Caldron  
 (Address) 4337 Madison

**15. FILED** Jan 30 1930 M. M. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 29 1930  
**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 \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Accidental Automobile  
Fracture of the neck  
2:10 P.M.  
2:12 P.M. (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
**CONTRIBUTORY (SECONDARY)** 1880 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

**DID AN OPERATION PRECEDE DEATH?** No DATE OF \_\_\_\_\_  
**WAS THERE AN AUTOPSY?** yes

**WHAT TEST CONFIRMED DIAGNOSIS?** Autopsy  
 (Signed) Stanley M. Crowe, M. D.  
1/29 1930 (Address) Deputy Coroner

\*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** Memorial Park Cemetery DATE OF BURIAL 1/31/30

**20. UNDERTAKER** Freeman Mortuary ADDRESS 104 W 42nd



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 399 File No. 1443  
 Township..... Primary Registration District No. 1002 Registered No. 435  
 City Kansas City (No. ....) St. .... Ward)

**2. FULL NAME**

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

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

FILED 1/30 19 30

M. M. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 19 30

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

auto accident, K.C.  
was coasting on sled

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [Signature], M. D. , 19 (Address) 29

\*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

19

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-1442