

APR 28 1930

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

Do not use this space.

8481

1. PLACE OF DEATH

County Henry
Township Walton
City (No.) St. Ward

Registration District No. 355
Primary Registration District No. 5498

File No.
Registered No. 3
St. Ward

2. FULL NAME John 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 56 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word). widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-18-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 6 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

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

10. NAME OF FATHER Robert Caldwell

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

12. MAIDEN NAME OF MOTHER Coal

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

14. INFORMANT Charley Caldwell
(Address) Irish Mo

15. FILED 4-10-30 W.E. Bergerly
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1930 to Mar 22 1930, and that I last saw him alive on Mar 22 1930, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

12 (duration) yrs. mos. 3 ds.

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

18. WHERE DISEASE CONTRACTED at place of death
IF NOT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) C. P. Smith, M. D.

3-25-1930 (Address) Irish 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 White Oak Cemetery DATE OF BURIAL 3-25-1930

20. UNDERTAKER H.P. Smith ADDRESS Irish Mo.

WRITE PLAINLY WITH UNFADING INK---THIS IS PERM. RECORD

K. 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.

