

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31574

State File No. _____

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 222

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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) 3
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community Home Months _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Sturgeon
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1940 hour 1 minute 20 P.M.
21. I hereby certify that I attended the deceased from
June, 1940, to Sept. 5, 1940;
that I last saw him alive on Sept. 4, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma
Duration 5 mo.

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Arthritis of Spine
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?
106 (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Lloyd B. Hutchins (M.D. or other) Reg.
Address Fulton, Mo. Date signed Sept 6, 1940

3. (a) PRINT FULL NAME Elizabeth Jane Caldwell

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex X 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife W. E. Caldwell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 17 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 6 18 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name John Dixon

13. Birthplace Kentucky
(City, town or county) (State or foreign country)

14. Maiden name etc

15. Birthplace etc
(City, town, or county) (State or foreign country)

16. (a) Informant John Hagan

(b) Address Fulton, Missouri

17. (a) Re-moval (b) Date thereof 9/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sturgeon, Missouri

18. (a) Signature of funeral director L. H. Wallace

(b) Address Fulton, Missouri

19. (a) Sept 6, 1940 (b) R. N. Creve
(Date received local registrar) (Registrar's signature)

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

X23159

578

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 *Harold J. Christey*

Licensed Embalmer No. *40021*

P. O. Address *Pultowa, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31574**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Callaway**
(b) City or town **Fulton**
(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 _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Jade Caldwell**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **18** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **2** year **1940** hour _____ minute _____ M.

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

Immediate cause of death **Carcinoma of colon, metastatic Carcinoma of Right lung.** Duration **Several months**

Due to _____

Due to _____

Other conditions **arthritis of spine** (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **Not permitted**

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **Floyd E. Hutchins** or other _____

Address **Fulton** _____ Date signed _____

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

SUPPLEMENTARY

