DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

44153

State File No.

JAN 22 1941

Registration District No.

Primary Registration District No. 874-6159 Registrar's No. 6159

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Arcadia Kans RFD #1
(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 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon

(c) City or town Arcadia Kans R.F.D. #1
(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.

3. (a) PRINT FULL NAME Elizabeth Caldwell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Chas Caldwell

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Feb (Month) 7 (Day) 1867 (Year)

8. AGE: Years 73 Months 10 Days 7 If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business

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

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

16. (a) Informant's own signature Chas Caldwell

(b) Address Arcadia Kan RFD #1

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

(c) Place: burial or cremation Warsley Cemetery

18. (a) Signature of funeral director H. T. Monahan

(b) Address Arcadia Kans

19. (a) Jan 6-1941 (Date received local registrar) (b) Mrs N. B. Prumm (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11 year 1940 hour 2 minute a M.

21. I hereby certify that I attended the deceased from 12/5 1940, to 12/11 1940, that I last saw alive on 12/5 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Apoplexy	
Due to Senility	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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) None

(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 H. N. Adamson (M. D. or other)

Address Arcadia Kans Date signed 12/18/40

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.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.