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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7525**  
Registrar's No. **306**

**FILED MAR 11 1943**  
Registration District No. **104**

Primary Registration District No. **201**

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

1. PLACE OF DEATH:

(a) County **St Louis**

(b) City or town **Glendale**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**140 Trevillian**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St Louis**

(c) City or town **Glendale**  
(If outside city or town limits, write "RURAL")

(d) Street No. **140 Trevillian**  
(If rural, give location)

(e) Citizen of foreign country?.....  
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Ada Way Caldwell**

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

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Widow**

6. (b) Name of husband or wife **Chas. Caldwell** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **July 7 1847**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>95</b>	<b>6</b>	<b>29</b>	hr. .... min.

9. Birthplace **St Louis Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Housewife**

12. Name **James C. Way**

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

14. Maiden name **Mary Ann Ellis**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **A.C. Caldwell**  
(b) Address **140 Trevillian, Glendale, Mo.**

17. (a) **Burial** (b) Date thereof **2-8-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine em.**

18. (a) Signature of funeral director **Louis H. Bopp, Inc.**  
(b) Address **131 W. Argonne Dr. Kirkwood, Mo.**

19. (a) **FEB 7 1943** (b) Registrar's signature **E. G. M. ...**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **6** year **1943** hour..... minute..... M.

21. I hereby certify that I attended the deceased from **Jan. 15**, 19**43**, to **Feb. 1**, 19**43**; that I last saw h. or alive on **Feb. 1**, 19**43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic pneumonia**

Due to **Atherosclerosis**

Due to.....  
Other conditions (Include pregnancy within 3 months of death).....

Major findings: Of operations.....  
Of autopsy.....

Duration

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?.....  
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **Paul E. Rutledge M.D.** (M. D. or other).....  
Address **Kirkwood, Mo.** Date signed **2-8-43**

**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.....

*Louis H Bopp*

Licensed Embalmer No.....

*921*

P. O. Address.....

**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. 752d

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: St. Louis  
 (a) County St. Louis  
 (b) City or town St. Louis  
 (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 Ada W. Caldwell  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 7, 1878  
 (Month) (Day) (Year)

8. AGE: Years 75- Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

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)  
 (Burial, cremation, or removal)

(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 MO (b) County St. Louis  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July Day 10 Year 1943 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_  
 that last saw him \_\_\_\_\_ alive on \_\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death: hypostatic pneumonia  
arteriosclerosis  
bronchial  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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)  
 (b) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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