

FILED MAY 3 1948

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000

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

1. PLACE OF DEATH:  
 (a) County Buchanan  
 (b) City or town St. Joseph  
 (c) Name of hospital or institution:  
St. Joseph Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 In this community 55 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Kansas (b) County Doniphan  
 (c) City or town Troy "Rural"  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John James Caulfield

3. (b) If veteran, name war no 3. (c) Social Security No. 712-01-5276

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

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

7. Birth date of deceased January 30 1882  
 (Month) (Day) (Year)

8. AGE:	Years <u>61</u>	Months <u>2</u>	Days <u>22</u>	If less than one day hr. _____ min.
---------	--------------------	--------------------	-------------------	--

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

10. Usual occupation Yard Clerk through Terminal R. R.

11. Industry or business \_\_\_\_\_

12. Name Michael J. Caulfield

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

14. Maiden name Mary Grogan

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

16. (a) Informant Mr. M. A. Caulfield  
 (b) Address St. Joseph, Missouri

17. (a) Burial (Burial, cremation, or removal) Mt. Olivet Cemetery  
 (b) Date thereof Apr. 24, 43  
 (Month) (Day) (Year)

18. (a) Signature of funeral director Herman W. S. S. S. S. S.  
 (b) Address 1802 Union, St. Joseph, Mo.  
 19. (a) 4-24-43 Rose Heagy  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
 year 1943 hour 4 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 21 1943 to April 22 1943; that I last saw him alive on April 22 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Coronary Thrombosis 4-21-43  
 (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)  
 (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 St. Joseph Mo (M. D. occupant)  
 Address \_\_\_\_\_ Date signed 4-22-43

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

**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 *John H. G. Curley*  
Licensed Embalmer No. *4050*  
P. O. Address *St. Joseph, 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.**