

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
I X36671

FILED APR 6 1944

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1242

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3-6-44-3-16-44  
(Specify whether years, months or days)

In this community Unknown

3. (a) PRINT FULL NAME JOE E. CALDWELL

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased July 4 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	8	12	hr. min.

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

10. Usual occupation Unemployed

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

12. Name Albert Caldwell

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

14. Maiden name Sophia Smith

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Removal (b) Date thereof 3-22-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Bluff Ark

18. (a) Signature of funeral director Adkins

(b) Address 2000 E. 12th K.C. Mo.

19. (a) 3-20-44 (b) D-C Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1407 E. 5th St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16  
year 1944 hour 2:10 minute P. M.

21. I hereby certify that I attended the deceased from March 6, 1944 to March 16, 1944  
that I last saw him alive on March 16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration \_\_\_\_\_

Due to Cerebral Sclerosis

Due to Senile Psychosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address St. Mary #2 600 E 22nd Date signed 3/19/44

**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 A.T. Moore

Licensed Embalmer No. 948

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.**