

FILED SEP 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26322

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 286

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cape Girardeau</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Fruitland</u>	
c. LENGTH OF STAY (in this place) <u>11 days</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Southeast Hospital</u>			

3. NAME OF DECEASED a. (First) <u>Ina</u> b. (Middle) <u>Martha</u> c. (Last) <u>Caldwell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 30 1949</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 22 1897</u>	9. AGE (in years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Near Fruitland Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Robert A. Caldwell</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth F. Short</u>		14. NAME OF HUSBAND OR WIFE _____	
--	--	---	--	-----------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Evelyn Caldwell</u> ADDRESS <u>Fruitland Mo</u>	
--	--	-------------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>About 2 yrs</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u>		
	DUE TO (c) <u>metastasis to brain about Aug 1-49</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
--	--	----------------------------------

22. I hereby certify that I attended the deceased from Aug 1, 1949 to Aug 30 1949, that I last saw the deceased alive on Aug 30, 1949, and that death occurred at 9:15 m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	23b. ADDRESS _____	23c. DATE SIGNED <u>8-31-49</u>
---	--------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 1-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Fruitland Mo</u>
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>8-31-1949</u>	REGISTRAR'S SIGNATURE <u>C. C. Summers</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Mo</u>
---	--	---

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

RECEIVED 9-6-49

District Health Officer No. 4

District File Number 949-1169

Date Filed _____

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed Thos K. Allen

Signed _____
Student Embalmer

Licensed Embalmer No. 4055

P. O. Address Jackson

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.