

FILED APR 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7409**

BIRTH NO. _____ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **4014** Registrar's No. **19**

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, write RURAL and give town) OR Fairfax		c. CITY (If outside corporate limits, write RURAL and give township) OR Rock Port, 0030	
c. LENGTH OF STAY (in this place) 10 da.		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fairfax Com. Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Theodore	b. (Middle)	c. (Last) Caudle	4. DATE OF DEATH (Month) (Day) (Year) 3 28 1951
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH 9/24/1868	9. AGE (In years last birthday) 82	10 UNDER 1 YEAR Months 6 Days 4	11 UNDER 1 MIN. Hours 4 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (State or foreign country) Hamburg, Iowa /	12. CITIZEN OF WHAT COUNTRY? Am.
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13a. FATHER'S NAME William Caudle	13b. MOTHER'S MAIDEN NAME Margaret Kirk	14. NAME OF HUSBAND OR WIFE XXX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Ethel Ray, Rock Port, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 Yrs 794 X F
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility		
	ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture right, head of femur.		30 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2/27/1951**, to **3/28/1951**, that I last saw the deceased alive on **3/27/1951**, and that death occurred at **2:00 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. R. ...	23b. ADDRESS Rockport, Mo.	23c. DATE SIGNED 3/29/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/30/1951	24c. NAME OF CEMETERY OR CREMATORY Greenhill Ce.	24d. LOCATION (City, town, or county) (State) Rock Port, Mo.
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DATE REC'D BY LOCAL REG. April 3, 1951	REGISTRAR'S SIGNATURE Marvin A. Schaefer 448	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BARTHOLOMEW MORTUARY, ROCKPORT, MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... *Geoff Bartholomew*

Licensed Embalmer No. 3173

Signed.....
Student Embalmer

P. O. Address Rock Port. 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.