

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35209

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 361

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1866</u>		9. AGE (In years least birthday) <u>91</u>		FUNDERS YEAR Months <u>0</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>122 Boonville Rd.</u>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>122 Boonville Rd.</u>				Length of stay in lb											

3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year		
<u>Emma Jane Caldwell</u>												<u>November 13, 1957</u>											

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and state or country) <u>Vandalia, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
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13a. FATHER'S NAME <u>John Thomas Hesser</u>			13b. MOTHER'S MAIDEN NAME <u>Sabina Ferguson</u>			14. NAME OF HUSBAND OR WIFE <u>Cecil C. Caldwell</u>					
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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 Address <u>Mrs. Cretee Ingels Jefferson City, Mo.</u>					
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>auricular fibrillation.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 d. w.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>coronary heart disease</u>												?	
DUE TO (c) <u>arterio-sclerosis.</u>												?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)								
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20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY			STATE		
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21. I attended the deceased from <u>1950</u> to <u>Nov. 12 57</u> and last saw <sup>her</sup> him alive on <u>Nov. 12, 57</u> Death occurred at <u>2:00 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.											
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22a. SIGNATURE (Name or title) <u>James G. Miller D.O.</u>						22b. ADDRESS <u>Jefferson City</u>						22c. DATE SIGNED <u>13 Nov. 57</u>					
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Nov. 15, 1957</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Vandalia, Mo.</u>					
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24. FUNERAL DIRECTOR <u>Doctor Breacher JCM</u>				ADDRESS <u>13 November 1957</u>				25. DATE RECD. BY LOCAL REG. <u>13 November 1957</u>				26. REGISTRAR'S SIGNATURE <u>R. P. Harris, MD - MR.</u>			
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS SEP 28 1959

FEB 13 1958

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.

Student .....  
Signature of Student Embalmer

Signed *Victor Breacher* .....

Licensed Embalmer No. 3701  
P. O. Address *J. C. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.