

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035631

STATE FILE NUMBER

FILED VS OCT 13 1960 264

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Bzart</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bzart</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Patersfield</u>		Length of stay in 1b <u>2 wks</u>		c. CITY OR TOWN <u>Patersfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Ed Caldwell</u>				4. DATE OF DEATH Month Day Year <u>9-5-60</u>				
5. SEX <u>m</u>	6. COLOR OF RACE <u>w</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-74</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or county) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>W. Caldwell</u>			13b. MOTHER'S MAIDEN NAME <u>Kent</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>?</u>			17. INFORMANT <u>Lester Thompson, Patersfield Mo</u>		
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>Cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DUE TO (b) <u>Generalized arteriosclerosis</u>							<u>3 years</u>	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of parotid gland</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
21. I attended the deceased from <u>1959</u> to <u>9/5/60</u> and last saw him <u>alive</u> on <u>July 1960</u> Death occurred at <u>7:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>M. L. Fowler MD</u>				22b. ADDRESS <u>West Plains Mo</u>			22c. DATE SIGNED <u>10/1/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9/8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Northside</u>		23d. LOCATION (City, town, or county) <u>Patersfield Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Kohertson West Plains Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-6-60</u>		26. REGISTRAR'S SIGNATURE <u>Thana Mahan</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *H. S. Roberts*

Licensed Embalmer No. 342

P. O. Address *West*

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.