

FILED DEC 12 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 119

Primary Registration District No. 4193

Registrar's No. 25

1. PLACE OF DEATH
 (a) County Gasconade
 (b) City or town Hermann
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Workmann Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
(Specify whether years, months or days)
 In this community 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Gasconade
 (c) City or town Hermann
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dr. Frank H. Caughell
 (b) If veteran, name war _____ (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month NOV. day 22
 year 1945 hour 5 minute 20 M.

4. Sex male () 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
 (b) Name of husband or wife Alice Caughell deceased (c) Age of husband or wife if alive years
 7. Birth date of deceased: Sept. 1 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 17
1945 to Nov 22, 1945
 that I last saw him alive on Nov 22, 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months 2 Days 21
 If less than one day _____ hr. _____ min.

Immediate cause of death Circulatory Collapse
 Due to Diabetic Coma
 Due to _____

9. Birthplace Chamois Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation: Physician

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

MOTHER FATHER { 11. Industry or business _____
 12. Name D. M. Caughell
 13. Birthplace St. Thomas Ontario
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Burnet
 15. Birthplace Virginia
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 22. If death was due to external causes, fill in the following:

16. (a) Informant F. J. Dubrouillet
 (b) Address: St. Louis, Mo.
 17. (a) Burial (b) Date thereof 11/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hermann

(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? _____

18. (a) Signature of funeral director _____
 (b) Address Hermann
 19. (a) 11/24/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature Howard [Signature] (M. D. or other) _____
 Address Hermann Date signed 11-23-45

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

1609

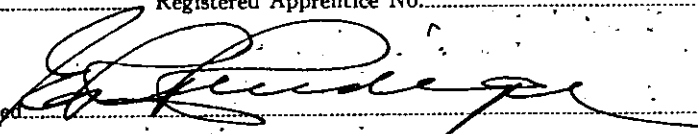
RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 12-11-15

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 me

working under my personal supervision.

Registered Apprentice No. _____

Signed 

Licensed Embalmer No. 2044

P. O. Address Hermann, 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.