

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County St Clair  
Township Osceola or Village \_\_\_\_\_ or City Osceola (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
Registration District No. 765 File No. 286305  
Primary Registration District No. 4460 Registered No. \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Henry Caldwell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Negro SINGLE MARRIED married  
WIDOWED OR DIVORCED (If file the word)

DATE OF DEATH July 1st, 1917  
(Month) (Day) (Year)

DATE OF BIRTH Jan 31st, 1868  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 10th, 1917, to July 1st, 1917,  
that I last saw him alive on June 30th, 1917,  
and that death occurred, on the date stated above, at 4:00 m.

AGE 49 yrs. 3 mos. 29 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Minister  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

cerebral hemorrhage

BIRTHPLACE (City or town, State or foreign country) Independence Mo

82A  
97 (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

NAME OF FATHER Charles Caldwell

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky

(Signed) H. D. Dalghish M. D.  
July 1st, 1917 (Address) Osceola Mo

MAIDEN NAME OF MOTHER Jane Killeck

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? \_\_\_\_\_

(Informant) Mr Chas H Caldwell

Former or usual residence \_\_\_\_\_

(ADDRESS) Osceola Mo

PLACE OF BURIAL OR REMOVAL Toupsmana Kan DATE OF BURIAL July 4, 1917

Filed July 3, 1917 Ruth Severn REGISTRAR

UNDERTAKER J. J. Martin ADDRESS Osceola, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthensia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

1 PLACE OF DEATH

County *St Clair*

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

Township \_\_\_\_\_  
or \_\_\_\_\_

Registration District No. *765*

File No. *90*

Village \_\_\_\_\_  
or \_\_\_\_\_

Primary Registration District No. *4460*

Registered No. \_\_\_\_\_

City *Osceola* (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Charles Henry Baldwin*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Negro* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *Jan 3 1868*  
(Month) (Day) (Year)

7 AGE *49 yrs 5 mos 29 ds.* If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work. *Minister*  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS  
10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_

15 Filed *Sept 10 1917* *Ruth Severs*  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 1st 1917*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191 to \_\_\_\_\_ 191 that I last saw him alive on \_\_\_\_\_ 191 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
*Cerebral Hemorrhage*  
*64*  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

CONTRIBUTORY *Arterial Sclerosis*  
(Secondary)  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.  
(Signed) *Ed. Dalghies* M. D.  
(Address) *Osceola Mo*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

505  
26305

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