

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

Do not use this space.

22860

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. City Hospital)

File No.....

Registered No.....

6528

St.....

Ward)

2. FULL NAME

Clara Caldwell

(a) Residence. No.....

2310

St.,

23

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

16

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

W. R. Caldwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 10 1854

7. AGE

YEARS
73

MONTHS
0

DAY
20

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

Self

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Tennessee

10. NAME OF FATHER

Tom Riley

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tennessee

12. MAIDEN NAME OF MOTHER

Clara Rankin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Hopkinton Tennessee

14.

INFORMANT

(Address)

Ch. Roman City Hospital

15.

FILED

18 1927

Mar. B. Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 15 1927

17. I HEREBY CERTIFY That I attended deceased from

June 15 1927 to July 14 1927
that I last saw him alive on *July 14 1927* and that death occurred, on the date stated above, at *12:40 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
(duration).....yrs.....mos.....ds.

CONTRIBUTORY (SECONDARY)

90B
(duration).....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Henry C. Westerman, M.D.*
7/15 1927 (Address) *City Hospital*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Matthews Cem July 18 1927

20. UNDERTAKER

ADDRESS

Weick Bros 220 St. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Caldwell.

70.