

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

Do not use this space.

**18062**

**1. PLACE OF DEATH**

County Linn  
Township Salt River  
City (No. 5901)

Registration District No. 682  
Primary Registration District No. 4406

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Rosa Caldwell Burkhead

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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 Alie Burkhead

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/7-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 / - / 1

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housewife 23 yrs. 3 mos. 3 da.  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) McCune Station  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Geo Caldwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Camden  
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Amanda Bidell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jenn  
(STATE OR COUNTRY) Mo

14. INFORMANT Ed Caldwell  
(Address) Ashburn Mo

15. FILED 5-9 1928 U.R. Brington  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/8 1928

17. I HEREBY CERTIFY That I attended deceased from April 30 1928, to May 8 1928  
that I last saw him/her alive on 4/28 1928, and that death occurred, on the date stated above, at 6:00 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Tuberculosis  
More than 2 yrs. 2 mos. 2 da.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) Charles P. Jeweller, M. D.

5/9 1928 (Address) Louisiana, Mo

\*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 Ashburn Mo DATE OF BURIAL 5/10 1928

20. UNDERTAKER P. Kaly ADDRESS Louisiana 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.

APR 9

Drug	Number of Patients
Chlorpromazine	120
Haloperidol	80
Lithium	50
Valproic Acid	30
Carbamazepine	20
Phenothiazines	10
Tricyclics	10
Antipsychotics	10
Antidepressants	10
Anticonvulsants	10
Anticholinergics	10
Antiparkinsonians	10
Antiemetics	10
Antihistamines	10
Antibiotics	10
Antifungals	10
Antivirals	10
Cardiovascular	10
Endocrine	10
Eye	10
Genitourinary	10
Respiratory	10
Skin	10
Systemic	10
Neurological	10
Other	10

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Cape Registration District No. 682 File No. ....  
 Township Salt River Primary Registration District No. 5901 Registered No. ....  
 City..... (No. ....) St. .... Ward)

2. FULL NAME Rosa Caldwell Bickhead  
 (a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1882

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<u>46</u>	<u>0</u>	<u>0</u>	<u>1</u>	

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

9. BIRTHPLACE (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....  
 (STATE OR COUNTRY) .....

14. INFORMANT .....  
 (Address) .....

15. FILED 59 19 28 D.R. Penington  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH?.....  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS?.....  
 (Signed)....., M. D.  
 , 19 (Address)

\*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 ..... 19.....

20. UNDERTAKER ..... ADDRESS .....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 K. All 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.

SUPPLEMENTARY

