

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

Do not use this space.

43161

1. PLACE OF DEATH

County Shelby
Township Taylor
City Lemora (No. _____)

Registration District No. 8331
Primary Registration District No. 6096

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Leonidas Caldwell

(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 man 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 OR Husband of Minnie Lenora Carmichael

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 25, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 10 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Drowning
(STATE OR COUNTRY) Schuylar Co., Mo

10. NAME OF FATHER William David Caldwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cynthiana
(STATE OR COUNTRY) Harrison Co., Ky

12. MAIDEN NAME OF MOTHER Mary Ann Church

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milton
(STATE OR COUNTRY) Lynn Co., Pa.

14. INFORMANT Mary Belle Bruton
(Address) _____

15. FILED Dec 29 1929 E. P. Gerard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

6. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 19 29

7. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
that I last saw him alive on Dec 21, 1929, and that death occurred, on the date stated above, at 7:12 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy cerebral
hemorrhage
Wied suddenly
82A (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 7401 (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 Clinical
(Signed) E. P. Gerard, M. D.

(Address) Leonard 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 Shelbyville Mo DATE OF BURIAL Dec 24 1929

20. UNDERTAKER John Hudson ADDRESS Edina Mo

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

