

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

Do not use this space.

32331

1. PLACE OF DEATH

County St. Louis Co.
Towship St. Ferdinand
City _____ (No. _____)

Registration District No. 784
Primary Registration District No. 6030

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

2. FULL NAME

(a) Residence, No. 7031 Idlewild St., _____ Ward _____
(Usual place of abode)

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 Male 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 Maudie Caldwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 7th 1852

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>8</u>	<u>0</u>	

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

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

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Maudie Caldwell
(Address) 7031 Idlewild

15. FILED 9/20 1931 D. Carl J. Kautz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/7 1931
17. _____

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1931, to Sept 6, 1931
that I last saw him alive on Sept 5, 1931, and that death occurred, on the date stated above, at 1 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
79 yrs. _____ mos. _____ ds.
1931
11/2

CONTRIBUTORY (SECONDARY) Ch. Coronitis + Asthma
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? At home
IF NOT AT PLACE OF DEATH? _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
(Signed) Albert Wael, M. D.
9/7, 1931 (Address) 5322 Helen

*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 Sparta Ill. DATE OF BURIAL Sept. 10 1931

20. UNDERTAKER Ecker + Son ADDRESS Sparta Ill.

SEP 25 1931

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.

