

REC'D JUL 12 1939

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

20263
Do not use this space.

1. PLACE OF DEATH

(a) County 1 Registration District No. 2
(b) Township 2 Primary Registration District No. 1003
(c) City St. Louis Mo. (d) Street No. BARNES HOSPITAL St. 5107
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. 434 Gwy. CALDWELL St. NR MAYFIELD, Ky.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Maragaret Caldwell.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 21 st 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 5 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Dairy worker
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Graves Co., Ky.

FATHER 13. NAME Bob Caldwell.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Graves Co., Ky.

MOTHER 15. MAIDEN NAME Elzia Gipson.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Margaret Caldwell. Mayfield, Ky.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland Park, Ky. DATE June 3th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C.R. Iupton & Sons. 2233 Delmar, Blvd., University City

20. FILED JUN 6 1939 J. B. Budach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 6th 1939

22. I HEREBY CERTIFY, That I attended deceased from 6 - 1 - 1939, to 6 - 6 - 1939.
I last saw him alive on 6 - 6 - 1939. Death is said to have occurred on the date stated above, at 2:30 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic Arteriosclerosis (post. meningitic) with cerebral edema
Date of onset 1938

Other contributory causes of importance: 1220
Diaphragmatic Hernia with pulmonary compression congested

Name of operation None Date of None
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? None Date of injury None, 1939
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify Remained 2 weeks
(Signed) J. B. Budach, M. D.
(Address) BARNES HOSPITAL

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Clarence H. Murray

or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Clarence H. Murray

Licensed Embalmer No.....

4011

P. O. Address.....

St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.