

FILED MAY 15 1940

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

15049
Do not use this space.

1. PLACE OF DEATH ²
 (a) County Howell Registration District No. 389
 (b) Township Maryotte Primary Registration District No. 5373
 (c) City Koshkoneg (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 36 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 436 Mary Caldiron
 (a) Residence, No. Koshkoneg Rt 2 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 OR WIFE Wesley Caldiron

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 21, 1873

7. AGE YEARS 68 MONTHS 0 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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) March 1940 11. Total time (years) spent in this occupation Lite

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell County Missouri

FATHER 13. NAME Jake Aleorn 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Any Davis 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Mrs. G.W. Beesley Brandsville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hottfield Cemetery March 29 1940

19. FUNERAL DIRECTOR (ADDRESS) Higgins botham Favoni Salem, Ark.

20. FILED 3-29 1940 Vida W. Simons Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 27 1940

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to 3-27 1940
 I last saw her alive on 3-27-40 Death is said to have occurred on the date stated above, at 6:00 P.M.
 The principal cause of death and related causes of importance were as follows:
Circulatory collapse in pneumonia Date of onset _____

Other contributory causes of importance: Myocardial infarction

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Richard Blaine, M. D.
344 Address Mammoth Spring Ark

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.

1 1 X1204

RECEIVED

District Health Officer No. 5,

District File Number 540 531

Date Filed 5/10/40

STATEMENT BY LICENSED EMBALMER

Not Embalmed

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10249

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 389

Primary Registration District No. 3543

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County. Howell
 (b) City or town. Myatt
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.
 In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Coldiron
 3. (b) If veteran, name war.
 3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced. m
 6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year.
 7. Birth date of deceased Apr 21 1873
 (Month) (Day) (Year)

8. AGE: Years 66 ~~68~~ Months 11 Days 6 If less than one day, hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name. (City, town, or county) (State or foreign country)

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant.
 (b) Address.

17. (a) (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal) (c) Place: burial or cremation.

18. (a) Signature of funeral director.
 (b) Address.

19. (a) 3-29-40 (b) Vida W. Simons
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State. (b) County.
 (c) City or town. (If outside city or town limits write "RURAL")
 (d) Street No. (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH. Month Mar day 27
 year 1940 hour. minute. M.

21. I hereby certify that I attended the deceased from 19. to 19. that I last saw him alive on 19. and that death occurred on the date and hour stated above.

Immediate cause of death

Due to
 Due to

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations.

Of autopsy

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).
 (b) Date of occurrence.
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Manner of injury.

23. Signature Mitchell Blaine (M. D. or other) Stor
 Address Stor Date signed.

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

