

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4373 West Pine Blvd. 2.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community
 years, months or days) 4 1/2

3. (a) PRINT FULL NAME Isaac Carpenter Caldwell3. (b) If veteran, name war unknown (c) Social Security No. 202-14-12094. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown years7. Birth date of deceased Feb. 14 1879
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
61 6 5 hr. min.9. Birthplace East Lynne Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Traffic Representative11. Industry or business Mo. Pacific R.R.12. Name unknown18. Birthplace unknown 9
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace unknown 9
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. E. Caldwell(b) Address 1507 Lincoln17. (a) Removal (b) Date thereof 8-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Little Rock, Ark.18. (a) Signature of funeral director Albert M. Hoppe(b) Address 4700 Washington Ave.19. (a) AUG 19 1940
(Received local registrar)(b) [Signature]
(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County.....
 (c) City or town Little Rock NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1507 Lincoln
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19
year 1940 - hour 8 minute 20 A.M.21. I hereby certify that I attended the deceased from July 15
1940 to Aug 19 1940, 1940that I last saw him alive on Aug 18 1940, 1940
and that death occurred on the date and hour stated above.Immediate cause of death.....
Hypertensive heart disease
Chronic nephritis

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature A. M. Hoppe (M. D. or other) 1Address 1703 8th St Date signed 8-19-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Signed *Albert W. Happer*

Licensed Embalmer No. *1861*

P. O. Address.....

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

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