DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

OCT 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31245

Registration District No. 1 Primary Registration District No. 1 Registrar's No. 225

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

1. PLACE OF DEATH:

1 (a) County Adair

2 (b) City or town Kirksville (If outside city or town limits, write "RURAL" and name of township)

2 (c) Name of hospital or institution: Grim-Smith Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Milan (If outside city or town limits write "RURAL")

0 (d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Russell Emerson Caldwell

3. (b) If veteran, name war No

3. (c) Social Security 500-14-5011

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 21, 1914 (Month) (Day) (Year)

8. AGE: Years 26 Months 1 Days 2 If less than one day hr. min.

9. Birthplace Milan, Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation Farm Helper. 0

11. Industry or business 0

FATHER
12. Name Geo. Albert Caldwell
13. Birthplace Sullivan Co. Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Gladys Opel Needham
15. Birthplace Sullivan Co. Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robt. Tipton.
(b) Address Milan, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Shatto Cem.

18. (a) Signature of funeral director Schoenes
(b) Address Milan, Mo.

19. (a) Sept. 25/40 (Date received local registrar) (b) Spencer L. Meeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23 year 1940 hour 6 minute 55 a M.

21. I hereby certify that I attended the deceased from Sept 21, 1940, to Sept 23, 1940; that I last saw him alive on Sept 22, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture Skull	2 day
Due to accident auto mobile	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Sept 21, 40
(c) Where did injury occur? Milan Sullivan Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? County road (Specify type of place)
3 While at work? (e) Means of injury

23. Signature A B Cranbrook (M. D. or other)
Address Kirksville Mo Date signed 9-23-40

(Licensed Embalmer's Statement on Reverse Side)

210 m
98

RECEIVED
District Health Officer No. 10
District File Number 10-40-2003
Date Filed OCT 24 1940

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 Frank D. Schoene, Registered Apprentice No. ..... working under my personal supervision.

Signed Frank D. Schoe

Licensed Embalmer No. 2016

P. O. Address Milan, W

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

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

. 2B
21-40
X22659

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Registration District No. 1 Primary Registration District No. 1 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Adair

(b) City or town Kirksville Mo.
(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 (Specify whether
In this community years, months or days)

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.

3. (a) PRINT FULL NAME Russell E. Caldwell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 26 Months 1 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
year 1940 hour minute M.

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

Immediate cause of death Fractured Skull accidental, automobile

Due to This man found in automobile on side of road apparently had run off road

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings Of operations into detch 210 M

Of autopsy 7 4

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) acc

(b) Date of occurrence Sept-21-1940

(c) Where did injury occur? Milan Sullivan Co (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Country road (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Date signed

5-31245