

S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32528

Registration District No. 549

Primary Registration District No. 3079

Registrar's No. 255

RECEIVED OCT 18 1940

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
902 ST John
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine M. Caldwell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 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 Dec. 5, 1930
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 8 23 hr. min.

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

10. Usual occupation 0

11. Industry or business 0

MOTHER FATHER { 12. Name Ray Caldwell
13. Birthplace Pike County, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mercedes Allen
15. Birthplace Hannibal, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Caldwell
(b) Address 902 St John, Hannibal Mo

17. (a) Burial (b) Date thereof Aug 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Granview Burial Park

18. (a) Signature of funeral director James Caldwell
(b) Address Hannibal Mo

19. (a) 9-3-40 (b) Dr. C. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 902 ST John
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28 year 1940 hour _____ minute 7¹⁵ P.-M.

21. I hereby certify that I attended the deceased from Aug 10 1940 to Aug 28 1940, 19____; that I last saw her alive on Aug 28 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Scarlet fever Duration 8 Mo

Due to Endo Carditis Chronic

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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) _____
(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) Means of injury _____

23. Signature CG Fisher (M. D. or other) _____
Address Hannibal Mo Date signed _____

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 _____

Ralph W. Clark, _____, Registered Apprentice No. 242
working under my personal supervision.

Signed _____

Michael J. O'Spence

Licensed Embalmer No. 3346

P. O. Address Hannibal, 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.