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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6673

State File No. _____

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Excelsior Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hours
(Specify whether years, months or days)
In this community 5 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
(c) City or town Route 5 North Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Route 50
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME RUFUS C. COLDWELL

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bernice Caldwell 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased June 12 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Collie Kennels

11. Industry or business Dog Business

12. Name Rufus A. Caldwell

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

14. Maiden name Kathryn Moore

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

16. (a) Informant Mrs. Bernice Caldwell

(b) Address Route 5, North Kansas City

17. (a) Removal (b) Date thereof 2/25/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Kansas City

18. (a) Signature of funeral director Herbert Hope

(b) Address Excelsior Springs

19. (a) Feb 26-1941 (b) Mrs. Pearl M. Crocker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1941 hour 10:30 minute 15 M.

21. I hereby certify that I attended the deceased from 2-24-41 1941 to 2-24- 1941

that I last saw him alive on 2-24-41 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to Prescribed hypotension

Due to Age

Other conditions (Include pregnancy within 3 months of death) 1770

Major findings: No operation

Of operations _____

Of autopsy NO

Duration

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

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)

Means of injury _____

23. Signature J. E. Poyner (M. D. or other)

Address Excelsior Springs Date signed 2-25-41

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

Scott Willis Lockensmith

Licensed Embalmer No. *3597*

P. O. Address *Galien, Spring, 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, fact should be so stated above.