

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:
5665 Cates Ave.
(If not in hospital or institution, write street number or location)

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

In this community life
years, months or days)

3. (a) PRINT FULL NAME JAMES WILLIAM CALDWELL

3. (b) If veteran, name war No

3. (c) Social Security No. 488-16-6987

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Clara Belle

6. (c) Age of husband or wife if alive 56 years
21 1897

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

8. AGE: Years 64 Months 0 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation clerk

11. Industry or business Title Ins. Corp.

12. Name Thomas J. Caldwell

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

14. Maiden name Nellie Worder

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

16. (a) Informant Mrs. J. W. Caldwell

(b) Address 5665 Cates Ave.

17. (a) burial (b) Date thereof 4/22/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Alexander & Sons

(b) Address 6175 Delmar Blvd.

19. (a) APR 21 1941 (b) J. T. Breakeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5665 Cates Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 20 year 1941 hour 4:45 minute P M.

21. I hereby certify that I attended the deceased from 1925 Occasionally, 19____, to _____, 19____; that I last saw him alive on 4-20-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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) _____

(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 W. H. Ounsted (M. D. or other)

Address 3720 Washington Date signed 4/21/41

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

MOTHER FATHER

Dr. Almustead
3720 Washington

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.....

Jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Delmas

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.