S. No. 2
M—1-4-41
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9516

Registration District No. 399 Primary Registration District No. 10-02 Registrar's No. 1113

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.General Hospital No.1
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 15 days (Specify whether
In this community 4 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1426 Charlotte
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME HAROLD CALDWELL

3. (b) If veteran, name war no

3. (c) Social Security No None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife ---

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

7. Birth date of deceased Nov. (Month) 2nd (Day) 1941 (Year)

8. AGE: Years | Months 4 | Days ~~15~~ 16 | If less than one day hr. min.

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

10. Usual occupation child

11. Industry or business

FATHER
12. Name Peter Caldwell
13. Birthplace Kansas (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Pearl Chapman
15. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Recor d clerk
(b) Address K.C.General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-42 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cem. KCKs

18. (a) Signature of funeral director P.B. Lapetina
(b) Address K.C. Mo.

19. (a) 3-19-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th year 1942 hour 5 minute 50 A.M. M.

21. I hereby certify that I attended the deceased from 3-3-42, 19 to 3-18-42, 19 ; that I last saw him alive on 3-18-42, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonocccic meningitis; post pneumonia; empyema bilateral

Due to Lobar Pneumonia

Due to 108

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy See above

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dwery R. Thom (M. D. or other)
Address Med.Dir.K.C.Gen.Hospital Date signed

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(Licensed Embalmer's Statement on Reverse Side)

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address.....

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.