

No. 2  
-8-43  
-17-39  
X37823

FILED JUN 1 1944  
Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 4695

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town: St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer Phillips Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days  
(Specify whether \_\_\_\_\_)

In this community 50 years  
(years, months or days)

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") 19

(d) Street No. 1711 (R) Franklin  
(If rural, give location) 9 25

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Lula Caldwell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16,  
year 1944 hour 2 minute 50 P.M.

21. I hereby certify that I attended the deceased from May  
8, 1944, to May 16, 1944;  
that I last saw her alive on May 16, 1944;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan ? 1865  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Carcinoma of the Rectum Duration Unk.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. Age at death about 79  
Years Months Days If less than one day  
79 7 hr. \_\_\_\_\_ min.

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

10. Usual occupation None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business NONE

12. Name Unknown

13. Birthplace Unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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 plus nurse (M. D. or other) \_\_\_\_\_  
Address 2601 Whitten Date signed 5/17/44

16. (a) Informant Mary Patton  
(b) Address 4202 Finney

17. (a) Burial (b) Date thereof 5-24-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Mary Wade  
(b) Address 4202 E. Finney

19. (a) MAY 27 1944 (b) J. F. Bredek  
(Date received by registrar) (Registrar's signature)

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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. *2769*

P. O. Address *Choubeac*

**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.**