

S. No. 2
OM-5-43
ev. 5-17-39
No. 1 X36671

19046

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 29 1944

Registration District No. 31944

Primary Registration District No. 3070

Registrar's No. 1147

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town WEBSTER GROVES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
404 PARK 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 3 DAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town KANSAS CITY 40
(If outside city or town limits, write "RURAL")
(d) Street No. 314-W-45th ST 3
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH SHANNON CALDWELL

3. (b) If veteran, name was SPANISH AMER. 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife JEWELL CALDWELL 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased JUNE 9 - 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 11 12 hr. min.

9. Birthplace COFFEYVILLE KANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation ELECTRICIAN

11. Industry or business TOWER THEATER

MOTHER FATHER
12. Name JOHN R. CALDWELL
13. Birthplace OTTUMWA IOWA
(City, town, or county) (State or foreign country)
14. Maiden name CLARRISSA JORDAN
15. Birthplace UNKNOWN KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs J S Caldwell

(b) Address 314 W 45th Kansas City

17. (a) REMOVAL (b) Date thereof MAY 21 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KANSAS CITY - MO.

18. (a) Signature of funeral director Parson and Co

(b) Address WEBSTER GROVES MO.
19. (a) MAY 22 1944 (b) E. H. Mc Warren, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21
year 1944 hour 2:30 minute A M.
21. I hereby certify that I attended the deceased from May 20
1944 to May 21 1944
that I last saw him alive on May 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Influenza
Due to _____
Duration 5 days
2 1/2 days

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

Major findings: Of operations _____
Of autopsy 99a
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 D. Seabaugh (M. D. or other) MD
Address Webster Groves Mo Date signed 5-21-44

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

6
7
4

340
29/44

MAY 29 1944

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.....

Leslie Welch

Registered Apprentice No. *362*

working under my personal supervision.

Signed *Bob Aldrich*

Licensed Embalmer No. *1332*

P. O. Address *Webster Groves*

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.