

FILED MAR 6 1945

Registration District No. 651945 Primary Registration District No. 4285

170000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Hale  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days)

In this community 60 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SADIE JOHN CALDWELL

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife John Caldwell 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug 15 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jackson Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Howard F. Tyler

13. Birthplace Jackson Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Shannon

15. Birthplace Swingston Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant John Caldwell

(b) Address Hale Mo.

17. (a) Burial (b) Date thereof 2-22-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale

18. (a) Signature of funeral director Brothers-Good

(b) Address Arriek Mo.

19. (a) Feb. 22 1945 (b) Mrs. Edgar Smith  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Hale  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1945 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from 20 1945 to Feb 20 1945 that I last saw him alive on Feb 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Sarcosina spiralis

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

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

Major findings: Sarcosina spiralis

Of operations \_\_\_\_\_

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

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) Manner of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address [Signature] Date signed 2/21-45

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**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 Brothers - Good - J. B. Brothers

Licensed Embalmer No. 2001

P. O. Address Richmond, 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.**