S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23457

FILED JUL 30 1945

Registration District No. 72 Primary Registration District No. 1000 Registrar's No. 778

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo (Specify whether years, months or days)
In this community 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 3426 Penn (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME George Alfred Caldwell
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Francis
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. (Month) 11 (Day) 1859 (Year)
8. AGE: Years 85 Months 8 Days 9 If less than one day hr. min.
9. Birthplace Doris Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired Stone Mason
11. Industry or business
MOTHER 12. Name unknown
FATHER 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
MOTHER 15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant C. Caldwell
(b) Address St Joseph Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cem
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) 7-23-45 (Date received local registrar) (b) Helen D. Gicke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 6 minute 15 P.M.
21. I hereby certify that I attended the deceased from June 21, 1945 to July 20, 1945; that I last saw him alive on July 20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary embolism	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Decubitus ulcer	3 wk
Major findings: Fracture left hip	
Of operations	
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) accident 131
(b) Date of occurrence 6/21/45
(c) Where did injury occur? St. Joseph, Missouri (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home -- 3426 Penn St. (Specify type of place)
While at work? no (e) Means of injury fall
23. Signature W. M. Jacobs M.D. (M.D. or other)
Address Social Welfare Board Date signed 7/23/45

1677 (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 Robert K. Gaple

Licensed Embalmer No. 3306

P. O. Address St Joseph, 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.