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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37174

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 973

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRING FIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GREENE 39
(c) City or town SPRING FIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 1040-E-CALHOUN
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME LOU ANN CALDWELL

3. (b) If veteran, name war None 3. (c) Social Security No. UNK

4. Sex 2 Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced O SINGLE

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Oct (Month) - 16 (Day) 1872 (Year)

8. AGE: Years 73 Months 1 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace UNKNOWN (City, town, or county) MO. O (State or foreign country)

10. Usual occupation None

11. Industry or business .....

FATHER
12. Name (UNKNOWN)
13. Birthplace UNK (City, town, or county) UNK (State or foreign country)

MOTHER
14. Maiden name UNK
15. Birthplace UNK (City, town, or county) UNK (State or foreign country)

16. (a) Informant WILLARD CALDWELL
(b) Address 630 - E - CENTRAL, Spfd., Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 (Month) - 28 (Day) - 45 (Year)
(c) Place: burial or cremation LINCOLN MEMORIAL

18. (a) Signature of funeral director Herbert V Smith
(b) Address 702 - N - Jefferson, Spfd., Mo.

19. (a) 11-27-45 (Date received local registrar) (b) Dr. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 - day 24 year 1945 hour 1 minute 45 P M.

21. I hereby certify that I attended the deceased from Sept. 15, 1945, to Nov. 15, 1945 that I last saw her alive on Nov. 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Fracture Hip

Due to FALL

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

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) Accident
(b) Date of occurrence 9-15-45
(c) Where did injury occur? Spfd. (City or town) Greene (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home - fell out of chair (Specify type of place)
While at work? No (e) Means of injury fall.

23. Signature C. E. Alfred (M. D. or other) MD.
Address Springfield Mo. Date signed .....

(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.....Herbert V. Smith.....

Licensed Embalmer No.....4286.....

P. O. Address.....Springfield.....

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. X