

S. No. 2  
OM-5-43  
v. 5-17-39  
No I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** JAN 21 1946

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**1232**

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1001

Registrar's No. 25

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:  
308 No Wheeling  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no  
(Specify whether in this community years, months or days)

In this community 41 yrs.  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Jackson 48

(c) City or town Kansas City, Mo 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 308 No Wheeling 8  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

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

**3. (a) PRINT FULL NAME** Mrs. Anna Mary Caldron

3. (b) If veteran, name war no

3. (c) Social Security No. MO

4. Sex FEMALE 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Patrick Caldron

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased 5 25 1867  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>78</u>	<u>7</u>	<u>8</u>	hr. min.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 3rd  
year 1946 hour 6 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 1943 to Jan 3rd 1946  
that I last saw h. alive on Jan 3rd 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Decompensated myocarditis 2 weeks

Due to Essential Hypertension 2 yrs.

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

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

Major findings: 95%

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

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

**PHYSICIAN**  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Kansas City MO. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

12. Name Unk. 4

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Charlotte Weger

15. Birthplace France 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Porter

(b) Address 308 No Wheeling

17. (a) Burial (b) Date thereof 1/5/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director John P. Sheil

(b) Address K. C.

19. (a) 1-4-46 Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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 J. J. Ciesik (M. D. or other) 20  
Address 5402 St John Date signed 1/4/46

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

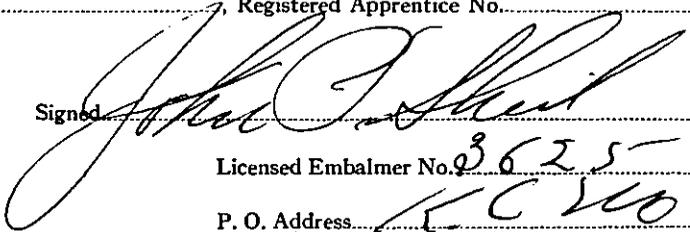
871

---

**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. 3625.....

P. O. Address RC 510.....

**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.**