

1-17-39  
X36671

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

FILED APR 5 1946

Registration District No. 212

Primary Registration District No. 5779

Registrar's No. 19

1. PLACE OF DEATH:  
(a) County: Miller  
(b) City or town: RURAL - FRANKLIN  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1 mi. North of Massers-Resor  
(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 mo 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Morgan  
(c) City or town: VERSAILLES  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country none

3. (a) PRINT FULL NAME: MARINE LUCILLE CALDWELL  
3. (b) If veteran, name was none  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MARCH day 17  
year 1946 hour 2 minute 30 A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex: Female  
5. Color or race: White  
6. (a) Single, widowed, married, divorced: Single  
6. (b) Name of husband or wife: \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: June 6, 1932  
(Month) (Day) (Year)

Immediate cause of death: Auto mobile accident, rushing going to  
entire body.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 13 Months 9 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace: VERSAILLES Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation: Student

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 3-17-46  
(c) Where did injury occur? Elton R. S. Miller, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
2 miles South Elton, Mo.  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

11. Industry or business: Schools  
12. Name: Wm O. Caldwell  
13. Birthplace: Morgan Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name: Ruth Kidwell  
15. Birthplace: Miller Co Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

16. (a) Informant: Blanche Connor  
(b) Address: Elton Mo  
17. (a) BURIAL (Burial, cremation, or removed) (b) Date thereof: 3-19-46  
(Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

23. Signature: M. E. Humphrey (Name or other) \_\_\_\_\_  
Address: Tusculum Mo Date signed: 3/18/46

18. (a) Signature of funeral director: M. Kidwell  
(b) Address: Versailles Mo  
19. (a) Mar. 18 '46 (Date received local registrar)  
(b) Abnerella Walt (Registrar's signature)

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(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-4-46

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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

*Keith M. Kaye*

Licensed Embalmer No. 3998

P. O. Address Eldon 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 19

Registration District No. 212

Primary Registration District No. 5779

1. PLACE OF DEATH: Miller rural

(a) County Miller rural

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

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

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

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

3. (a) PRINT FULL NAME Marnie L. 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 S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 6 (Month) (Day) (Year)

8. AGE: Years 13 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day)

\_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 7  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Auto accident  
Broken Neck. Crushed internally.

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

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

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations \_\_\_\_\_

Of autopsy 1700-11 210

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 Overturned Auto

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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