

No. 2  
1-2-43  
5-17-39  
I X35697

Registration District No. **178** **FILED** **MAR 18 1946**

Primary Registration District No. **3054**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County Polk  
(b) City or town Louisiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 hrs  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State MO (b) County St. Louis  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 9  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country: X

**3. (a) PRINT FULL NAME** Troy Junior Caldwell  
**3. (b) If veteran,** name war NO  
**3. (c) Social Security** 4694-24-6679

**20. DATE OF DEATH:** Month 17<sup>th</sup> day Feb  
year 1946 hour 9 minute 45 P.M.  
**21. I hereby certify that I attended the deceased from** 17<sup>th</sup> Feb 9 AM  
1946 to 17<sup>th</sup> Feb PM, 1946  
that I last saw him alive on 17 Feb, 1946 7<sup>45</sup> PM 1946  
and that death occurred on the date and hour stated above.

**4. Sex** male **5. Color or race** white **6. (a) Single, widowed, married,** divorced  
**6. (b) Name of husband or wife.** X **6. (c) Age of husband or wife if** 8 years  
**7. Birth date of deceased.** March (Month) 1920 (Day) (Year)

Immediate cause of death Shock, hemo-  
thorax, and hemo pericard-  
ium  
Due to traumatic fractures of  
ribs post. Right chest wall  
Due to Automobile Accident  
at approx 5<sup>30</sup> AM, 17 Feb 1946  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**8. AGE:** Years 19 Months 11 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
**9. Birthplace** Clinton (City, town, or county) Ark (State or foreign country)  
**10. Usual occupation.** Student

Major findings:  
Of operations \_\_\_\_\_ **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
Of autopsy \_\_\_\_\_

**11. Industry or business.** \_\_\_\_\_  
**12. Name** Dearell Caldwell  
**13. Birthplace** Clinton (City, town, or county) Ark (State or foreign country)  
**14. Maiden name** Volley May Gales  
**15. Birthplace** Clinton (City, town, or county) Ark (State or foreign country)  
**16. (a) Informant** Mr. Dearell Caldwell  
**(b) Address** 4679 Washington Ave St. Louis  
**17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb 19 1946 (Month) (Day) (Year)  
**(c) Place: burial or cremation** St. Louis, Mo.  
**18. (a) Signature of funeral director** Grace Bankhead  
**(b) Address** Bowling Green Mo.  
**19. (a) 2/17/46** (Date received local registrar) **(b) Margaret E. Stephens** (Registrar's signature)**

**22. If death was due to external causes, fill in the following:**  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ 82  
(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** Chas. H. Lovell (M. D.)  
Address Louisiana Mo. Date signed 17/2/46

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

RECEIVED

District Health Office No. 10

District File Number. 3-46-53

Date Filed MAR 16 1946

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 *Grace M. Bankhead*

Licensed Embalmer No. *2904*

P. O. Address *Bowling Green, 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

Registration District No. 278 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Pike Louisiana

(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 \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Tracy J. Caldwell

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

4. Sex m 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 Mar 8 1928  
(Month) (Day) (Year)

8. AGE: Years 17 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day \_\_\_\_\_ 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 Myocardial Infarction + Coronary Thrombosis + Shock

Due to Crushing injury of Rib cage with multiple fractures

Due to Auto sliding from street Highway slightly

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

Major findings: \_\_\_\_\_

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

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 17 Feb. 1946

(c) Where did injury occur? Near Bowling Green Pike Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on Highway 61

While at work? no (e) Means of injury \_\_\_\_\_

23. Signature Clas H. Twillen (M. D. or \_\_\_\_\_)

Address Louisiana Mo. Date signed 3/23/46

SUPPLEMENTARY

9:30 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10383