

No. 2
2-43
5-17-39
X35897

35863

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 18 1946

Registration District No. _____

Primary Registration District No. 4575

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan

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

(c) Name of hospital or institution: Simpson Hospital
(If not in hospital or institution, write street number or location)

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

In this community 7 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Sullivan / 05

(c) City Osage Junction Mo 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

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

If yes, name country _____

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

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

20. DATE OF DEATH: Month 10 day 20
year 1946 hour 4 minute 45 a.m.

21. I hereby certify that I attended the deceased from Oct. 13
1946, to Oct. 20, 1946
that I last saw her alive on Oct. 20, 1946
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife J. Marion Caldwell 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased 6 - 10 - 77
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 4 days

8. AGE: Years Months Days If less than one day

69 4 10 hr. _____ min.

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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

10. Usual occupation Sullivan Co 1110 7

11. Industry or business Housewife

12. Name James Baldridge

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

14. Maiden name Margaret Hess

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations 4 3 A

Of autopsy _____

16. (a) Informant Mrs Forest McCleskey

(b) Address Milan Mo

17. (a) burial (b) Date thereof 10 22 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood - Milan Mo

18. (a) Signature of funeral director Schamus

(b) Address Milan Mo

19. (a) Oct 31 - 1946 (b) Mrs. H. B. Harris
(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 Ed Simpson (M. D. or other) DO

Address Milan Date signed 10-21-46

521 (Licensed Embalmer's Statement on Reverse Side)

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



RECEIVED
 District Health Officer No. _____
 District File Number 10-46-2011
 Date Filed NOV - 8 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..... Dwight Schaefer

Licensed Embalmer No. 2667

P. O. Address Milwaukee - Wis

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.

Registration District No. 381

Primary Registration District No. 4511-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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)

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 Jennie J. Caldwell
(b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH: Month _____ (Day) _____
year 1946 hour _____ minute _____ M.

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____ to _____, 19____
that I last saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

7. Birth date of deceased June 10
(Month) (Day) (Year)
8. AGE: Years 69 Months 7 Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Housewife
11. Industry or business Farmers wife

Major findings:
Of operations _____
Of autopsy _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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)
(c) Means of injury _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Oct 31-1946 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

35863