

FILED JAN 13 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39614

Registration District No. 17

Primary Registration District No. 5264

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Christian
 (b) City or town Bradleyville Rural Seneca
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Seneca Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Four Years (Specify whether
 In this community Four Years
 years, months or days)

3. (a) PRINT FULL NAME James Caudill3. (b) If veteran, name war No 3. (c) Social Security No. None4. Sex M 5. Color or race Wht 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Vina Eldridge 6. (c) Age of husband or wife if alive 13 years7. Birth date of deceased Nov 13 1866
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
82 0 17 hr. min.9. Birthplace ? Ky.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business

12. Name William M. Caudill
13. Birthplace ? Ky.
(City, town, or county) (State or foreign country)14. Maiden name Susie Caudill
15. Birthplace ? Ky.
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Elbert Horner(b) Address Bradleyville, Mo.17. (a) Burial (b) Date thereof 12-2-1948
(Burial, cremation, or removal) Old Boston, Mo. (Day) (Year)(c) Place: burial or cremation Oldfield, Mo.18. (a) Signature of funeral director John Dean Harris(b) Address Clever, Mo.19. (a) Jan 3 - 1949 (b) Lillie Barr
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian
 (c) City or town Bradleyville Rural Seneca
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30
year 1948 hour 7:30 minute P.M.21. I hereby certify that I attended the deceased from Sept - 12 1948 to Nov - 30 1948
that I last saw him alive on Nov - 15 1948
and that death occurred on the date and hour stated above.Immediate cause of death Myocarditis & acute cardiac dilatation DurationDue to Carcinoma

Due to

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)

(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) Means of injury

23. Signature John W. Kilbuck M. D. ofAddress Sparta, Mo. Date signed 1-48

RECEIVED

District Health Officer No. 6,

District File Number 149-56

Date Filed 1-11-49

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..... John Dean Harris
Licensed Embalmer No. 4390
P. O. Address Cleveland, 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. Jan
Registrar's No. 32

Registration District No. 67 Primary Registration District No. 5264

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Rural
(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

3. (a) PRINT FULL NAME JAMES CAUDILL
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Nov 13 1924
(Month) (Day) (Year)

8. AGE: Years 82 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 _____ Year 1948 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 _____ Duration _____

Due to Chronic Myocarditis, local carcinoma on free
Due to this cancer as a complication

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

Major findings:
Of operations _____
Of autopsy _____

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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

S-39614