

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29299

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buch.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (In this place) <u>6 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>806 Court, Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>806 Court Street</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Florence</u>	b. (Middle) <u>Virginia</u>	c. (Last) <u>Caldwell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 1, 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 11, 1867</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Artrip, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Marion Artrip</u>	13b. MOTHER'S MAIDEN NAME <u>Unkown</u>	14. NAME OF HUSBAND OR WIFE <u>B. O. Caldwell</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ottis Caldwell</u>	ADDRESS <u>Milan, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>4421</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic nephritis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 9-1, 1949 to 9-1, 1949, that I last saw the deceased alive on 9-1, 1949, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>A. Grant M.D.</u>	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>9-1-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Sept. 1, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Milan, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Sept 8, 1949</u>	REGISTRAR'S SIGNATURE <u>G. B. Jenkins</u>	382	EMERAL DIRECTOR'S SIGNATURE <u>Stamey Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Charles M. Fisman

Licensed Embalmer No. 4487

P. O. Address St. Joseph

**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.