

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4937
Registrar's No. 4937

BIRTH NO. #37793 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4826 Easton	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) MARTHA	b. (Middle) CALDWELL	c. (Last)	(Month) June	(Day) 3rd	(Year) 1950

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH 7-9-1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 Hrs. Hours	IF UNDER 1 Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Pugh Lamb	13b. MOTHER'S MARRIEN NAME Frances Drumms	14. NAME OF HUSBAND OR WIFE John
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Walter Caldwell	ADDRESS 4826 Easton
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cholelithiasis with gallstone ileus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	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? 58 ft
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22. I hereby certify that I attended the deceased from 5/22/50, 19, to 6/3/50, 19, that I last saw the deceased alive on 6/3/50, 19, and that death occurred at 6:50 pm m., from the causes and on the date stated above.

23a. SIGNATURE Dorcas Bailey	(Degree or title) M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 6/5/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-5-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Jonesboro Ark
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DATE REC'D BY LOCAL REG. JUN 5 1950	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *J. Allen Davis Jr*
Licensed Embalmer No. *4053*
P. O. Address *St Louis, 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.