

26091

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

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

FILED JUL 14 1954

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 5432 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>R.F.D. # 4 SULLIVAN</b>		c. LENGTH OF STAY (in this place) <b>57 YR., 5</b>	c. CITY OR TOWN _____
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R.F.D. #4 SULLIVAN MO</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>R.F.D. # 4 SULLIVAN MO</b>		1100	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GEORGE</b>	b. (Middle) <b>FRANKLIN</b>	c. (Last) <b>CALDWELL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>7 7 1954</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7-6-1877</b>
9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>BURNSIDE ILL.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>George W Caldwell</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Stevens</b>	14. NAME OF HUSBAND OR WIFE <b>Emma Pope</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Marvin Caldwell Sullivan Mo.</b> ADDRESS _____	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Arteriosclerosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis heart disease</b> DUE TO (c) <b>Senility</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>  <b>Years</b>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) _____	
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? _____	
22. I hereby certify that I attended the deceased from <u>May 16, 1954</u> , to <u>June 30, 1954</u> , that I last saw the deceased alive on <u>June 30, 1954</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>M. A. Peterson M.D.</b>		23b. ADDRESS <b>40 1/2 N. Clark St. Sullivan Mo.</b>	23c. DATE SIGNED <b>July 8 1954</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-11-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Reedville Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>R.F.D. #4 Sullivan Mo.</b>
DATE REC'D BY LOCAL REG. <b>7/10/54</b>	REGISTRAR'S SIGNATURE <b>Thomasa. Humphrey</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Thos P. Shaffer</b> ADDRESS <b>Sullivan Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

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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 <sup>NOT</sup> embalmed  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Paul F. Knoellen*

Licensed Embalmer No. *263*

P. O. Address *Suller*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.