

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **32339**BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5132 Registrar's No. 1116

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). --a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural Wayne Township) c. LENGTH OF STAY (In this place) 2 months		c. CITY OR TOWN St. Joseph d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Route 8		e. STREET ADDRESS (If rural, give location) 3002 North 7th St.	

3. NAME OF DECEASED (Type or Print)	a. (First) ROSA	b. (Middle) BELLE	c. (Last) CALDWELL	4. DATE OF DEATH Oct. 19, 1955
-------------------------------------	------------------------	--------------------------	---------------------------	---------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 13, 1869	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 Mins. Mins.
----------------------	-------------------------------	---	--	---	------------------------	----------------------	-----------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign Country) Andrew County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	--	--

13a. FATHER'S NAME Christine Moutray	13b. MOTHER'S MAIDEN NAME Pheobe Gray	14. NAME OF HUSBAND OR WIFE John Caldwell
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Bessie Wheeler	ADDRESS Route 8
--	-------------------------------------	--	------------------------

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, arteria, 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) Cordian decompensation		2 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____		years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Emphysema.		4200	years.
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 10/30/50, 19____, to 10/19/55, 19____, that I last saw the deceased alive on Aug. 24, 1955, and that death occurred at 9:15a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Willie P. McDonald	23b. ADDRESS M. D. 301 N. 8th St., St. Joseph, Mo.	23c. DATE SIGNED 10/20/55
--	---	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 21, 1955	24c. NAME OF CEMETERY OR CREMATORY Rochester Cemetery	24d. LOCATION (City, town, or county) (State) Rochester, Mo.
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. Oct 21, 1955	REGISTRAR'S SIGNATURE Ethel M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Clara A. Clark	ADDRESS St. Joseph, Mo.
--	---	--	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
E. A. Clark

Licensed Embalmer No.....

P. O. Address.....
St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.