

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
**57 021946**

**FILED JUL 1 1957**

Registration District No. **241** Primary Registration District No. **5-228** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY <b>NEW MADRID</b>		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LESIEUR TWP.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>PORTAGEVILLE</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HOME</b> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>2 MI. E. PORTAGEVILLE</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOE</b> Middle <b>RILEY</b> Last <b>CALDCLEUGH</b>			4. DATE OF DEATH <b>JUNE 10, 1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED: <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 5, 1914</b>
9. AGE (In years last birthday) <b>43</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE SHINER</b>	11. BIRTHPLACE (City and state or country) <b>ST. CHARLES, ARK.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE SHINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAY LABORER</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOE CALDCLEUGH</b>		14. MOTHER'S MAIDEN NAME <b>SULA MINOR</b>	
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 <b>JESSE CALDCLEUGH</b> Address <b>EAST ST. LOUIS, ILL.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NO MEDICAL ATTENDANT AT TIME OF DEATH</b> DUE TO (b) <b>PREVIOUS RECORD OF DOCTOR TREATING FOR</b> DUE TO (c) <b>ULCERATED STOMACH</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>5400</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Ellen De Gula</i> (Degrees or title) <i>3</i>		22b. ADDRESS <i>Portageville Mo</i>	22c. DATE SIGNED <i>6-17-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 13, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PORTAGEVILLE COLORED</b>	23d. LOCATION (City, town, or county) (State) <b>PORTAGEVILLE, MISSOURI</b>
24. FUNERAL DIRECTOR <b>DELISLE FUNERAL PARLOR</b> ADDRESS <b>PORTAGEVILLE, MO</b>	25. DATE RECD. BY LOCAL REG. <b>6-17-57</b>	26. REGISTRAR'S SIGNATURE <i>Ellen De Gula Milner</i>	

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED JUN 28 1957  
NEW MADRID CO. HEALTH CENTER

P. J. S.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 44

P. O. Address Waycross

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