

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002354
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 50

300
1-57

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sedalia		c. CITY OR TOWN Sedalia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 820 West 4th		d. STREET ADDRESS (If outside, give location) 820 West 4th	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES OSCAR CALDWELL		4. DATE OF DEATH Month Day Year January 30, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Urban transportation	11. BIRTHPLACE (City and state or country) Pettis County, Mo.
13a. FATHER'S NAME James R. Caldwell		13b. MOTHER'S MAIDEN NAME Emma Raines	14. NAME OF HUSBAND OR WIFE Nannie Willett Caldwell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 491-07-5530	17. INFORMANT Mrs. Nannie Caldwell, 820 West 4th Sedalia, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accidents</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Embolism</u> DUE TO (c) _____ 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 2 yr
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>Dec 5, 57</u> to <u>Jan 29, 59</u> and last saw <u>him</u> alive on <u>1/30/59</u> Death occurred at <u>10 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. L. Holden MD</u>		22b. ADDRESS <u>1116 ex. rd Sedalia Mo</u>	22c. DATE SIGNED <u>1/31/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/2/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Ridge Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Green Ridge, Missouri</u>
24. FUNERAL DIRECTOR <u>Shane Caring</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 1, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *P. E. Baker*

Licensed Embalmer No. *2419*
P. O. Address *Seclavia*

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.