

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 6 3 5 6  
STATE FILE NUMBER

FILED VS JAN - 4 1960 3/7

Registration District No. \_\_\_\_\_ Primary Registration District No. 500 Registrar's No. 3389

UNINDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Charles The First Nursing Home</b>		Length of stay in 1b <b>6 Wks.</b>		c. CITY OR TOWN <b>Pine Lawn</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>7004 Glenmore Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7004 Glenmore Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>S.</b> Last <b>Caldwell</b>				4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/73</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister &amp; Missionary (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ministry</b>		11. BIRTHPLACE (City and state or country) <b>Arlington, Wisc.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Caldwell</b>		13b. MOTHER'S MAIDEN NAME <b>Marian Wardrop</b>		14. NAME OF HUSBAND OR WIFE <b>Esther E. Caldwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Esther E. Caldwell, Glenmore 7004</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b>	
IMMEDIATE CAUSE (a) <b>arteriosclerosis generalized</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>with hemiplegia due to</b>							
DUE TO (c) <b>cerebral thrombosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ s.m. _____ p.m. Month, Day, Year _____							
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 <b>12/18/59</b> to <b>12/18/59</b> and last saw him alive on <b>12/15/59</b> Death occurred at <b>5:55 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>James O. Wood M.D.</b>				22b. ADDRESS <b>35 North Central</b>		22c. DATE SIGNED <b>12/19/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>12/21/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery St. Louis County, Mo</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral, 1905 Union Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>12-19-59</b>		25. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

32 N. CENTRAL  
Pa 6-0683  
Hrs. 1-5 Sat.

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.