

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029685

FILED VS SEP 12 1960

042

1000

944

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

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| 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, give TOWNSHIP only) OR TOWN St. Joseph | Length of stay in 1b Most of life | c. CITY OR TOWN St. Joseph | Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Mo. Meth. Hospital | | Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | d. STREET ADDRESS (If outside, give location) 2010 Boyd Street |
| Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |

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|---|-------------------------------|--|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Claude Middle A. Last Caldwell | | | 4. DATE OF DEATH Month September Day 6, Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 25, 1891 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Construction Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Hy-Way | | 11. BIRTHPLACE (City and state or country) Kidder, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME George Alfred Caldwell | | 13b. MOTHER'S MAIDEN NAME Mary Frances Embs | | 14. NAME OF HUSBAND OR WIFE Stella Caldwell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW #1 | | 16. SOCIAL SECURITY NO. 491-10-6477 | | 17. INFORMANT Address Mrs. Dorothy Fike St. Joseph, Mo. | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural Causes - Unattended Death Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Investigated by City Health Dept DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH |
| 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"/> N. <input type="checkbox"/> Unknown |

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| 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 _____ a.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 _____ to _____ and last saw her/him alive on _____
Death occurred at **3:30 A.** _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Robert W. Kieber, M.D. | 22b. ADDRESS St. Joseph, Mo | 22c. DATE SIGNED 9-7-60 | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | 23b. DATE Sept. 8, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri. |

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| 24. FUNERAL DIRECTOR Meighopper, Felkeman, Inc. | ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Sept. 8, 1960 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Hardell |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 13 1960

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 Edward B. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Jose

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