

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1256

1. PLACE OF DEATH

County Henry
Township Clinton
City Clinton (No.)

Registration District No. 347
Primary Registration District No. 3018

File No.
Registered No. 21
St. Ward

2. FULL NAME

Elinbeth Caldwell

(a) Residence, No. North 2nd St., Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

James Caldwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Nov 17 1846

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>82</u>	<u>2</u>	<u>about</u>	<u>know</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

North Carolina

10. NAME OF FATHER

Calvin E Walker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Don't know

14. INFORMANT

Mrs. Claud Jenkins
(Address) Clinton Mo

Jan 24 1929 Dr. E. C. Peeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-23 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-10 1929, to 1-23 1929, that I last saw him alive on 1-10 1929, and that death occurred, on the date stated above, at 3 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Constriction of
Heart by lungs
92
125-13
111 lbs

CONTRIBUTORY (SECONDARY) mitral insufficiency
(duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 8
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) E. Walker, M. D.

1-23, 1929 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Montrose Mo **DATE OF BURIAL** 1/24 1929

20. UNDERTAKER Spore + Son **ADDRESS** Clinton Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE IN FULL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

EB 2 1929

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31

