

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

Do not use this space.

32833

1. PLACE OF DEATH

County Worth
Township Union
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 904
Primary Registration District No. 6215

File No. _____
Registered No. _____

2. FULL NAME

Washington W. Aldrich

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 20 1857

7. AGE
YEARS MONTHS DAYS
73 6 13
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Vaughn Co
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Gustavus Aldrich

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

12. MAIDEN NAME OF MOTHER Susan Rollins

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

14. INFORMANT Mrs. W. W. Aldrich
(Address) Sheridan Mo

15. FILED Sept 2 1929 J. W. Nigh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2nd 1929

17. I HEREBY CERTIFY, That I attended deceased from May 10 1929 to Sept 2 1929, and that I last saw him alive on Sept 2 1929, and that death occurred, on the date stated above, _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stenosis of Coronary Artery of the Heart.

94B
112 (duration) yrs. 4 mos. 28 ds.

CONTRIBUTORY (SECONDARY) Bronchial Asthma
(duration) 20 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) John W. Nigh M. D.
Sept 2, 1929 (Address) Sheridan 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 Sheridan Cemetery **DATE OF BURIAL** Sept 4 1929

20. UNDERTAKER Long & Boyd **ADDRESS** Sheridan

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 FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

CT 24 1929

