

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

Do not use this space.

32981
248

1. PLACE OF DEATH

County B. one
Township 6 d d r
City New Hartford (No. _____)

Registration District No. 73
Primary Registration District No. 5112

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Earle H. Aldridge
(a) Residence. No. 515 Cherry St. _____ Ward _____

(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE single 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) white

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 31-1905

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
24 7 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Government Works
(b) General nature of industry, business, or establishment in which employed (or employer) Wood Enst. Co
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Clay Center

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

14. INFORMANT

(Address) Mr. J. H. Aldridge
515 Cherry St

15. FILED

10/17, 1929

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15th 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Drowned - Accidental

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

9 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. L. Davis, Coroner, Mo.

10/15, 1929 (Address) Columbia 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

DATE OF BURIAL

National Cem 10/18 29

20. UNDERTAKER

ADDRESS

Lawson Maunier Jeff City

WRITE PLAINLY, WITH UNFAADING INK--THIS IS A PERMANENT RECORD.

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.

U. S. N. G. I.
by the
y. p. prob.

U. S. N. G. I.

100-10000

WRITE PAINLY, WITH INK---THIS IS A PERMANENT RECORD NOV
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S WORLD ELAT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Boone

Registration District No. 73

File No. _____

Township Cedar

Primary Registration District No. 5112

Registered No. 248

City _____

(No. _____)

St. _____

Ward _____

2. FULL NAME

Carl Lee Aldridge

(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

m

4. COLOR OR RACE

w

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

s

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

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

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1
day, _____ hrs.
or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

Dec 4 19 19 Beatrice Grubb

REGISTRAR

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Oct 15 19 29

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(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or
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DATE OF BURIAL

19 _____

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ADDRESS

S-32981