

2
13-40
7-39
X23159

Registration District No. **576**

Primary Registration District No. **5765**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Wyatt-Rural
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 9 30 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Eugene Thomas Aldridge

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased January 13, 1879
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 10 If less than one day hr. min.

9. Birthplace Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Same

12. Name Joe Aldridge

13. Birthplace N.K.

14. Maiden name Victoria Nunn

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Archie Aldridge

(b) Address Wyatt, Mo Box 428

17. (a) Burial (b) Date thereof 9/24/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Golden Pond Kentucky

18. (a) Signature of funeral director Lair-Nunnelee

(b) Address Charleston, Missouri

19. (a) 9-27-40 (b) F A Vernon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Mississippi
(c) City or town Wyatt-Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Box 428
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
year 1940 hour 3 minute 8 M.

21. I hereby certify that I attended the deceased from May 1940 to Sept 23 1940
that I last saw him alive on Sept 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Ca. of left lung (Primary)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) HT

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 745

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature E. Ches Polving (M. D. or other) _____
Address Charleston Mo Date signed 9/26/40

Duration
5 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 2

District File Number 1040-15

Date Filed 10/3/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed E. E. Junnelee

Licensed Embalmer No. 4164

P. O. Address Charleston, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.