DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34886

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1154

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 days (Specify whether years, months or days)
In this community 58 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2701 Renick St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: William Gilbert Alders
3. (b) If veteran, name war: None
3. (c) Social Security No: 491-09-3178
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: June (Month) 7 (Day) 1876 (Year)
8. AGE: Years 64 Months 4 Days 24 If less than one day ____ hr. ____ min.
9. Birthplace: Weston (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Traveing Salesman (Retired)
11. Industry or business: Wyeth Hardware Co.

MOTHER FATHER
12. Name: William Theo Alders
13. Birthplace: Unknown (City, town, or county) Holland (State or foreign country)
14. Maiden name: Rosina Kurtz
15. Birthplace: Weston (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Lorena Dunbar
(b) Address: 2701 Renick St. St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 2, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Olivet Cemetery
18. (a) Signature of funeral director: H. O. Sidenfaden & Son
(b) Address: 1802 Union St. St. Joseph, Mo.
19. (a) Nov 1 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31st year 1940 hour 3 minute 20 P.M.
21. I hereby certify that I attended the deceased from 10-1, 1940, to 10-31, 1940 that I last saw him alive on 10-31, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemiplegia	30 days
Hypertension	3 yrs
Cerebral sclerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Chronic alcoholism	

Major findings: Of operations: ✓
Of autopsy: not yet reported

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

22. If death was due to external causes, fill in the following:
(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? 85 (Specify type of place)
While at work? (e) Means of injury

23. Signature: Thomas Redmond (M. D. or other)
Address: 928 Kirkpatrick Bldg. Date signed: 11-1-40

(Licensed Embalmer's Statement on Reverse Side)

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 Albert C. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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.

. No. 2B
-2-21-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Wm Gilbert Alden
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 64 Months 4 Days 24 If less than one day min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 12-13-40 (Date received local registrar) (b) [signature] (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemiplegia	
Due to: Cerebral Hemorrhage	
Due to: Hypertension	1
Due to: General Sclerosis	
Due to	
Other conditions: Chr. alcoholism (Include pregnancy within 3 months of death)	

Major findings:
Of operations $24
Of autopsy

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

22. If death was due to external causes, fill in the following:
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Thomas Redmond (M.D. or other)
Address 326 Public Service Bldg Signed 12-12-40

SUPPLEMENTARY