

WHITE PAPER - USE UNFADING BLACK INK - MAKE 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.

ED MAR 19 1949
Registration District No. **235**

Primary Registration District No. **3634**

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **mobley mo**
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **HARDIN ALDERSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Nellie Alderson** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years **about 56** Months **23** Days _____ If less than one day hr. _____ min. _____

9. Birthplace **Jacksonville** **MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business **W. D. A.**

12. Name **Frank Alderson**

13. Birthplace **MO.**
(City, town, or county) (State or foreign country)

14. Maiden name **Charlotte** **MO.**
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature **Mrs. Nellie Alderson**

(b) Address **908 Fisk Ave**

17. (a) **burial** (b) Date thereof **Feb 21-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oakland Cem.**

18. (a) Signature of funeral director **Robert L. Carr**

(b) Address **417 N. 8th St**

19. (a) **Feb 21-41** (b) **Leah Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **mo.** (b) County **Randolph**
(c) City or town **mobley**
(If outside city or town limits, write "RURAL")
(d) Street No. **908 Fisk Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **2/48** day **18th**
year **41** hour **3** minute **10** A.M.
21. I hereby certify that I attended the deceased from **7/15/41**
to **7/18/41**, 19____
that I last saw h _____ alive on **2/18/41**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized peritonitis**
Due to **Perforated Appendix**
Due to **12/11**

Other conditions (Include pregnancy within 3 months of death) **12/11**

Major findings: Of operations **Perforated Appendix**
Of autopsy **Generalized peritonitis**

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 **F. L. McComister** (M. D. or other) **4/19/48**
Address **McComister** Date signed

RECEIVED

District Health Officer No. 10

District File Number 3-41-566

Date Filed MAR 10 1941

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.....

Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Moberg Mo.

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

If this body is not embalmed, above space should be left blank.