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35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 1, 194[illegible]

Registration District No. [illegible]

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15107

Primary Registration District No. 4287

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Troy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County Lincoln 57

(c) City or town Troy 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) O

If yes, name country

3. (a) PRINT FULL NAME ELIZABETH AYDELOTT

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female | 5. Color or race White | 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) 30 (Day) 1852 (Year)

8. AGE: Years	Months	Days	If less than one day
91	5	20	hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Robert Dowell
13. Birthplace Lincoln County (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harper
15. Birthplace Lincoln County (City, town, or county) (State or foreign country)

16. (a) Informant Warren E. Aydelott
(b) Address Troy

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetary

18. (a) Signature of funeral director [illegible]
(b) Address Troy Mo

19. (a) May 23 44 (Date received local registrar) (b) Mrs Fay Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month February day 20 - 1944
year hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 15, 19[illegible], to Feb 20, 1944, that I last saw h[illegible] alive on Feb 20, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	5 days
Due to Senility	
Due to [illegible]	
Other conditions. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

108

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 Jos. Lebeck M.D. (M. D. or other)

Address Troy, Mo Date signed 5/21/44.

1186

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-28-44

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 Marion Markham

Licensed Embalmer No. 2461

P. O. Address Huntsville

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

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 1

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Troy
(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
In this community (Specify whether years, months or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lincoln
(c) City or town Troy
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elizabeth Aydelett
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Wm Thomas Aydelett
6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Aug (Month) 30 (Day) 1855 (Year)

8. AGE: Years 91 | Months 5 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Lincoln County (State or foreign country) Missouri

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) (Date received local registrar) (b) Mr Guy Jackson (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day
year 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	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 (M. D. or other)
Address Date signed

15107