. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 20 1945

Registration District No. 310

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3058

State File No. 10506

Registrar's No. 23

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lincoln
(c) City or town Old Monroe (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 Chas. P? Aldridge
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 Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased July (Month) 12 (Day) 1938 (Year)

8. AGE: Years 6 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Tulsa (City, town, or county) Oklahoma (State or foreign country)
10. Usual occupation School child
11. Industry or business

FATHER
12. Name W.F.Aldridge
13. Birthplace Harwood (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Lola Farmer
15. Birthplace Iona (City, town, or county) S.D. (State or foreign country)

16. (a) Informant W.F.Aldridge
(b) Address Old Monroe Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 45 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo.
18. (a) Signature of funeral director Oakley
(b) Address O'Fallon Mo.
19. (a) 2-19-1945 (Date received local registrar) (b) Ernest B. Faule (Registrar's signature)

1540

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1945 hour 5 minute A M.
21. I hereby certify that I attended the deceased from 2-12-45, 19—, to 2-17, 1945 that I last saw her alive on 2-16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia (Coba)	
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 H.L. Newlin (M. D. or other) MD
Address Old Monroe Mo. Date signed 2-18-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-19-45

MAR 23 1945

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 Ed Kattley

Licensed Embalmer No. 877

P. O. Address Fallon Nev

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, fact should be so stated above.