V. S. No. 2
20M—8-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14677

Registration District No. 325 Primary Registration District No. 4479 Registrar's No. 22

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

1. PLACE OF DEATH:
(a) County Schuyler
(b) City or town Queen City (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 75 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Schuyler
(c) City or town Queen City (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 JOHN ALDRIDGE
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Mo
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margert Aldridge
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased unknown unknown 1870 (Month) (Day) (Year)
8. AGE: Years 75 Months X Days X If less than one day —hr. —min.
9. Birthplace Schuyler (City, town, or county) 0 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Bill Aldridge
13. Birthplace Schuyler (City, town, or county) 0 (State or foreign country)
MOTHER 14. Maiden name Charlotte Fletcher
15. Birthplace Schuyler (City, town, or county) 0 (State or foreign country)
16. (a) Informant Otis Farris
(b) Address Queen City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Ap 2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Crowder
18. (a) Signature of funeral director B O Fenton
(b) Address Lancaster Mo
19. (a) Apr. 2, 1945 (Date received local registrar) (b) A. A. Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30 year 1945 hour 10 minute a. M.
21. I hereby certify that I attended the deceased from —, 19—, to —, 19—;
that I last saw him alive on mch 10, 1945 and that death occurred on the date and hour stated above.
Immediate cause of death Was heart failure following paralysis 3 yrs. before, he was totally blind (Duration)
Due to I never did treat him
Due to Only time I seen him was mch. 10-45
Other conditions — (Include pregnancy within 3 months of death)
Major findings:
Of operations Never examined him
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. E. Gerwig (M. D. or other)
Address Downing Mo. Date signed

1278 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-45-739
Date Filed MAY 4 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 P. O Fenton

Licensed Embalmer No. 2705

P. O. Address Lancaster 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, fact should be so stated above.