7. S. No. 2
OM—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25228

FILED AUG 2 1945

Registration District No. 243 Primary Registration District No. 6154 Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Essex rural Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(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 13 months

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

3. (a) PRINT FULL NAME Rovena Eldridge
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 Widowed
6. (b) Name of husband or wife Alfred Eldridge
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased March (Month) 22 (Day) 1861 (Year)

8. AGE: Years 84 Months 4 Days 2 If less than one day hr. min.

9. Birthplace Oran (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business None
FATHER 12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant W. H. Barnett
(b) Address Essex, Mo. RI
17. (a) (Burial, cremation, or removal) (b) Date thereof 7-24-1945 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Essex Mo
18. (a) Signature of funeral director Watkins
(b) Address Dexter Mo
19. (a) July 30-45 (Date received local registrar) (b) Nora Lyons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 2 A.M. minute 10 M.
21. I hereby certify that I attended the deceased from 7-21 1945, to 7-24 1945, that I last saw he alive on 7-21 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
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 J. M. Barnes M.D. (M. D. or other)
Address Malden Mo. Date signed 7/25/45

1129

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 745-98
Date Filed 7-31-4

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.....

Licensed Embalmer No.....

P. O. Address.....

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.