

42554

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

FILED JAN 14 1946

Registration District No. 324

Primary Registration District No. 3072

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
834 North Jefferson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 23 Years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Effie Fadelia Aldredge

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

7. Birth date of deceased March 13 1880
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 19 If less than one day
hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Neal Rensing

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof 12/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cemetery

18. (a) Signature of funeral director J. L. L. L. L.

(b) Address Marshall, Mo.

19. (a) 12-4-45 (b) Mrs. T. West
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97
(c) City or town Marshall 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. 834 North Jefferson
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1945 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from Sept. 14 1945 to Dec. 2 1945
that I last saw h. is alive on Dec. 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
arterial hypertension

Due to arterial hypertension

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 130

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Blair M. D. (M. D. or other) Marshall, Mo.

Date signed 12-3-45

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-11-45

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

J. Leslie Surring

Licensed Embalmer No. 3235

P. O. Address

Marshall, 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.