

FILED APR 6 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 5977

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Polk (Union)  
(b) City or town Aldrich Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3 1/2 mi. E. of Aldrich  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 84  
(c) City or town Aldrich Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3 1/2 mi. E. of Aldrich  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country None

3. (a) PRINT FULL NAME Adelle Golden Childress

3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 21  
year 1946 hour 4 minute 0 M.

21. I hereby certify that I attended the deceased from Mar 20, 1946 to 19\_\_\_\_, 19\_\_\_\_, that I last saw her alive on Mar 20 - 1946; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race wh 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Archie Julian Childress 6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased Aug 21 1892  
(Month) (Day) (Year)

Immediate cause of death pharynx  
In Coma when seen

8. AGE: Years 53 Months 7 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Polk Co Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

Other conditions (include pregnancy within 3 months of death)

11. Industry or business Housework

12. Name Benjamin Waggoner

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

14. Maiden name Jannie Clark

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

16. (a) Informant A. J. Childress

(b) Address Aldrich Mo.

17. (a) Burial (b) Date thereof 3-26-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mitchell Camp Ground

18. (a) Signature of funeral director Lillie Frieze  
(b) Address Baldwin Mo.

19. (a) Mar 29 1946 (b) Lillie Frieze  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy gta  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
23. Signature L. J. Waggoner (M. D. or other) \_\_\_\_\_  
Address Waldport Mo Mar 25 1946

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

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**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. 3092  
P. O. Address. Salinas, M.

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 285Primary Registration District No. 5977

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Polk  
 (b) City or town Rural  
 (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. \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_  
years, months or days)

## 3. (a) PRINT FULL NAME

Addie G. Childress

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F5. Color or race W6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

53

hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) mo

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (e) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) March 29, 1946 (b) \_\_\_\_\_

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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