

**FILED APR 10 1946 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 323

Primary Registration District No. 6090

Registrar's No. 63

**1. PLACE OF DEATH:**

(a) County Saline  
(b) City or town Liberty township  
(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 75 Years  
years, months or days

**3. (a) PRINT NAME Gertrude Halsey Aulger**

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife John F. Aulger 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 28th, 1865  
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 6 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Dr. Thomas J. Halsey  
13. Birthplace New York  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Dewildrick  
15. Birthplace Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Aulger  
(b) Address Sweet Springs, Mo. R # 1

17. (a) Burial (b) Date thereof Mch. 8, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park cemetery

18. (a) Signature of funeral director Charles R. Marshall  
(b) Address Marshall, Mo.

19. (a) 3/11/46 (b) Dolly Andrew  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Saline 97  
(c) City or town Liberty township 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? ✓ (Yes or No) 0  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 6 th  
year 1946 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept. 2  
1945 to 3-6-1 1946  
that I last saw him alive on 3-5- 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Asmphygia  
Due to anoxia 10 yrs.  
Due to arteriosclerosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 A. C. Ryman (M. D. or other) \_\_\_\_\_  
Address Marshall Mo Date signed 3-7-46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-9-46

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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

*Jas. H. Lewis*

Licensed Embalmer No. 1171

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.**