

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44734**

Registration District No. **12**

Primary Registration District No. **5052**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Rural Roaring River twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Eagle Rock Star Rt.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **all of life**
years, months or days

3. (a) PRINT FULL NAME **James Harvey Aldridge**

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex **Male** 0
5. Color or race **White**

6. (a) Single, widowed, married,
divorced **Married**

6. (b) Name of husband or wife
Annie Aldridge

6. (c) Age of husband or wife if
alive **73** years

7. Birth date of deceased **March 1, 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 **4** **24** hr. min.

9. Birthplace **Barry County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

12. Name **Monroe Aldridge**

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

14. Maiden name **Tilda**

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

16. (a) Informant **Annie Aldridge**

(b) Address **Star Rt., Eagle Rock, Mo.**

17. (a) **Burial** (b) Date thereof **7/28/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Aldridge Cemetery**

18. (a) Signature of funeral director **Koon Funeral Home**

(b) Address **Cassville, Mo.**

19. (a) **June 2, 1948** (b) **Mrs. Mrs. Hudson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Star Rt., Eagle Rock, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **D**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25**
year **1947** hour **6** minute **30** A.M.

21. I hereby certify that I attended the deceased from
1945, 19 **July**, 19 **20**, 19 **47**
that I last saw him alive on **July 1, 20, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pericarditis chronic**

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 **0**

23. Signature **Blair M. Salter M.D.** (M. D. or other)

Address **Cassville, Mo.** Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

W. C. Koon

Licensed Embalmer No.

4359

P. O. Address

Cassville, 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. *3/21/11*