

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

40676

State File No.

FILED DEC 22 1951

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| BIRTH NO. | | REG. DIST. NO. <u>42</u> | | PRIMARY REG. DIST. NO. <u>1000</u> | | Registrar's No. <u>1295</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Dickinson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u> | | c. LENGTH OF STAY (In this place) <u>8 yrs 6 m 7 ds</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | | 3118 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kate Hospital #2 St Joseph</u> | | | | d. STREET ADDRESS (If rural, give location) <u>923 Washington Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Catherine Aldridge</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12 15 1951</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>not given</u> | |
| 9. AGE (In years last birthday) <u>84</u> | | 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ill</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | 13a. FATHER'S NAME <u>Andrew Armstrong</u> | | 13b. MOTHER'S MAIDEN NAME <u>Pascinda Rogers</u> | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Nil</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>C. S. Sams MD Kate Hospital & send</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lactic Carcinoma</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>10 years</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>151X</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 1st, 1951</u> , to <u>12-15</u> , 1951, that I last saw the deceased alive on <u>12-15</u> , 1951, and that death occurred at <u>11:52 a.m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>C. S. Sams MD</u> | | 23b. ADDRESS <u>Kate Hospital #2 St Joseph</u> | | 23c. DATE SIGNED <u>12-15-1951</u> | | | |
| 24a. EMBALMER'S REMOVAL (Specify) | | 24b. DATE <u>12/18/51</u> | | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION (City, town, or county) (State) <u>Kirkville Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>Dec. 18, 1951</u> | | REGISTRAR'S SIGNATURE <u>Carl C. Easter</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman W. Sidenfaden</u> | | ADDRESS <u>1802 Union</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.