

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

35036

State File No. _____

FILED NOV 2 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1121</u>	
1. PLACE OF DEATH a. COUNTY <u>Douglas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>			
b. CITY OR TOWN <u>St Joseph</u>		c. LENGTH OF STAY (in this place) <u>26 days</u>		c. CITY OR TOWN <u>Guilford Mo</u>		p740	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>				d. STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Florence</u>		b. (Middle) <u>Aldridge</u>		c. (Last) <u>Aldridge</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 26 1953</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>Feb 24 1874</u>	
9. AGE (in years last birthday) <u>79</u>		10. MONTHS <u>8</u>		11. DAYS <u>2</u>		12. IF DECEASED IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, OR OTHER U.S. SERVICE, GIVE BRANCH, GRADE, AND SERVICE NUMBER	
10a. 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 (City and State or Foreign Country) <u>Chaplin Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13a. FATHER'S NAME <u>George J. Sappington</u>		13b. MOTHER'S M maiden name <u>Lillian</u>		14. NAME OF HUSBAND OR WIFE <u>John Aldridge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Rel</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Missess Kelly</u>		ADDRESS <u>Guilford Mo</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>Myocarditis</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>10 yrs</u> DUE TO (c) <u>Psychotic gradual onset</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min)		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>9-30</u> , <u>1953</u> , to <u>10-26</u> , <u>1953</u> that I last saw the deceased alive on <u>10-26</u> , <u>1953</u> , and that death occurred at <u>8:25 PM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Type or Print) <u>O. E. Cossine M.D.</u>		23b. ADDRESS <u>State Hospital # 2</u>		23c. DATE SIGNED <u>10-26-1953</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10-31-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Graves Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Guilford Mo</u>	
DATE REC'D BY LOCAL REG <u>Oct 28, 1953</u>		REGISTRAR'S SIGNATURE <u>Arthur M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Breit Funeral Home</u>		ADDRESS <u>Guilford Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

E. C. Breit

Licensed Embalmer No. *2650*

P. O. Address *Swansea 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.