

STANDARD CERTIFICATE OF DEATH

State File No. **21754**

FILED AUG 15 1955

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PERMANENT RECORD

623 West Walnut

WRITE PLAINLY—USING UNFADING INK—MISSOURI  
SPRINGFIELD, MISSOURI

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>200</u>		Registrar's No. <u>699</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>2 Weeks</u>		c. CITY OR TOWN <u>Springfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Springfield Baptist Hosp</u>				e. STREET ADDRESS (If rural, give location) <u>440 South Main Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SHERMAN</u>		b. (Middle) <u>A.</u>		c. (Last) <u>ALDRIDGE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 10, 1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug. 5, 1880</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Mts. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Veterinary Medicine</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13a. FATHER'S NAME <u>Sam Aldridge</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda McCain</u>			14. NAME OF HUSBAND OR WIFE <u>Lucy M. Aldridge</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>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marjorie Wood Springfield, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Pylorogastri</u>				<u>4-5 mo.</u>	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>				<u>20 yr.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>6-0-00</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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>May 8, 1955</u> , to <u>Aug. 10, 1955</u> , that I last saw the deceased alive on <u>Aug. 10, 1955</u> , and that death occurred at <u>9a.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James T. Good MD</u>				23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>8-12-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 11, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8/13/55</u>		REGISTRAR'S SIGNATURE <u>Edith Williams</u>		25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS <u>Springfield, Mo</u>			

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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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No....4..5.

P. O. Address..Springfield

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.