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

FILED AUG 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26946

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5140 Registrar's No. 148

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Lingo twp.
c. LENGTH OF STAY (In this place) 25yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 miles S. New Cambria

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Macon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Lingo twp. 0610 0
d. STREET ADDRESS (If rural, give location) 2 miles S. New Cambria

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Alvin c. (Last) Aldridge

4. DATE OF DEATH (Month) (Day) (Year) August 15, 1955

5. SEX Male 0

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1

8. DATE OF BIRTH March 9, 1886

9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months 5 Days 6 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS OR INDUSTRY Own farm

11. BIRTHPLACE (State or foreign country) Strasburg, Mo. 0

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John M. Aldridge

13b. MOTHER'S MAIDEN NAME Elizabeth West

14. NAME OF HUSBAND OR WIFE Josephine Aldridge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service) -----

16. SOCIAL SECURITY NO. 486-12-3239

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Josephine Aldridge, New Cambria

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart failure — 2 wks.
DUE TO (c) Anemia chronic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 4201

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 17, 1955, *to* Aug 15, 1955, *that I last saw the deceased alive on* Aug 15, 1955, *and that death occurred at* 8:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE James Campbell M.D. (Degree or title) — 23b. ADDRESS Macon, Missouri — 23c. DATE SIGNED 15 Aug 55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 8-17-55 — 24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery — 24d. LOCATION (City, town, or county) (State) Pleasant Hill, Mo.

DATE REC'D BY LOCAL REG. 8/15/55 — REGISTRAR'S SIGNATURE Ruth McNeely 185 0 — 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Lilliland New Cambria Mo

(Licensed Embalmer's Statement on Reverse Side)

AUG 2[illegible] 19[illegible]

(29)

RECEIVED 8.20.55
MACON COUNTY HEALTH DEPARTMENT
County File No. 8.55.131
Date Filed 8.23.55

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~~

H. J. Gilleland Student Embalmer No. .....

working under my personal supervision.

Signed H. J. Gilleland

Signed .....
Student Embalmer

Licensed Embalmer No. 4018

P. O. Address New Cambria Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.