

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043913

STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 1

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Howell</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u> | |
| b. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Length of stay in <u>4 mos</u> | | | |

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|---|---------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Lila Ann Aldridge</u> | | | 4. DATE OF DEATH Month Day Year <u>12/4-58</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-28-1951</u> | | 9. AGE (In years, 1st birthday) <u>87</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |

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|--|--|---|-------------------------------------|--|---|---|--|
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> | | 11. BIRTHPLACE (City and state or country) <u>Hale, Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edw. Hayes</u> | | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE <u>M. L. Fowler</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) | | | 16. SOCIAL SECURITY NO. <u>442X</u> | | 17. INFIRMARY Address <u>West Plains Mo</u> | | |

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|--|--|--|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Institution, acute renal failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>Cardiovascular renal disease</u> | | | <u>10 years</u> | | |
| DUE TO (c) <u>Diuit</u> | | | <u>10 years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | |

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|---|--|--|--|--|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. | | | | | |

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|--|--|--|--|---|--|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>11/1/58</u> to <u>12/4/58</u> and last saw her alive on <u>12/2/58</u> Death occurred at <u>12:50 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |

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|---|--|------------------------------------|--|----------------------------------|--|
| 22a. SIGNATURE (Degree or title) <u>M. L. Fowler MD</u> | | 22b. ADDRESS <u>West Plains Mo</u> | | 22c. DATE SIGNED <u>12/10/58</u> | |
|---|--|------------------------------------|--|----------------------------------|--|

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|---|--|--------------------------|--|--|--|--|--|
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u> | | 23b. DATE <u>12/6-58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> | | 23d. LOCATION (City, town, or country) (State) <u>West Plains Mo</u> | |
|---|--|--------------------------|--|--|--|--|--|

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| 24. FUNERAL DIRECTOR <u>Kaberton's West Plains Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-2-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> | |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1939 FEB 2

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 *J. L. Roberts*

Licensed Embalmer No. *3437*

P. O. Address *West Park*

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.