

Health,
Welfare
Public
Service

FILED VS AUG 1 0 1959

STANDARD CERTIFICATE OF DEATH

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 107

300
1-57
2

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>STover</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 <u>ST. Josephs Hospital</u>		Length of stay in 1b <u>24 hr</u>	d. STREET ADDRESS (If outside, give location) <u>STover</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>George</u> Last <u>Alderman</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>October 28, 1889</u>		9. AGE (In years last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Clyde KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Riley Alderman</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Hess</u>		14. NAME OF HUSBAND OR WIFE <u>Ruby Ray Alderman</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>495-36-5930</u>	17. INFORMANT Address <u>Myrtle Robinson STover, Missouri</u>		
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>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>					<u>unknown</u>
DUE TO (c) _____					<u>331X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Weakness</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK 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>AUGUST 1, 1959</u> to <u>AUGUST 2, 1959</u> and last saw her alive on <u>AUGUST 2, 1959</u> Death occurred at <u>11:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William A. Alch, MD</u>		22b. ADDRESS <u>329 HA IN BOONVILLE, MISSOURI</u>		22c. DATE SIGNED <u>8-3-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>August 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STover Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>STover, Missouri</u>
24. FUNERAL DIRECTOR <u>James R. Scoville, M.D.</u>		ADDRESS <u>Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/3/59</u>	26. REGISTRAR'S SIGNATURE <u>D. Hooper</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AUG 1 1 1959

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 *James R. Scumir*

Licensed Embalmer No. *4850*
P. O. Address *Verona, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.