RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030202

FILED VS SEP 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7726 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 5 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess Hosp.
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 5230 Jamieson
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CLARA Middle: C. Last: ALDERSON
4. DATE OF DEATH: Month Aug. Day 19 Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 1-6-89
9. AGE (last birthday): 70
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (City and state or country): Webb City, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Merriman Castleberry
13b. MOTHER'S MAIDEN NAME: Henrietta Short
14. NAME OF HUSBAND OR WIFE: W. D. Alderson
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.: None
17. INFORMANT: Ralph Alderson, 137 W. Mermod Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebrovascular accident — 5 days
DUE TO (c): Hypertension 331X — 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days: ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 8-15-59, to 8-19-59 and last saw her/him alive on 8-19-59
Death occurred at 7:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Lois C. Hyatt (Degree or title) M. D.
22b. ADDRESS: 134 N. Adams
22c. DATE SIGNED: 8-20-59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 22, 59
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cem.
23d. LOCATION (City, town, or county) (State): Kirkwood, Mo.
24. FUNERAL DIRECTOR ADDRESS: Parker-Aldrich, Webster Groves
25. DATE RECD. BY LOCAL REG.: AUG 20 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Leslie Nolch

Licensed Embalmer No. 4395

P. O. Address Webster St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.