URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-031806

FILED VS AUG 24 1960

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7932

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — COUNTY: Clinton
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Unknown — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle — Last ALDAG
4. DATE OF DEATH: Month 8 — Day 10 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 4/30/88
9. AGE (last birthday): 72 — 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): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Minden, Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Fred Aldag
13b. MOTHER'S MAIDEN NAME: Fredricka Aston
14. NAME OF HUSBAND OR WIFE: Unknown
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.: Unknown
17. INFORMANT: William Henson — Address: Carlyle, Ill.

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) Bullet wound of Head
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 976x
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Self inflicted

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) in room # 433 of Missouri
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 8 10 60 Pacific Hospital on or about Aug 10 1960
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.) Hosp
20f. CITY, TOWN, OR LOCATION: St Louis — COUNTY — STATE Mo

BY AFFIDAVIT OF

21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 1025 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Paul Johnson (Degree or Title) Coroner Deputy
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 8/11/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8/12/60
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cem.
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.
24. FUNERAL DIRECTOR — ADDRESS: McLAUGHLIN'S, 2301 Lafayette
25. DATE RECD. BY LOCAL REG.: AUG 11 1960
26. REGISTRAR'S SIGNATURE: Paul Smith M D

OCT 14 1960

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_____

Licensed Embalmer No._____

P. O. Address_____

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