

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

DEATH

Registration District No. 673  
 Primary Registration District No. 5-896  
 File No. 25-452  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John C Aldridge  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7-1857

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.  
72 14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER Samuel Aldridge

11. BIRTHPLACE OF FATHER (CITY OR TOWN) W  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

14. INFORMANT Mrs J C Aldridge  
 (Address) Postal Town

15. FILED Aug 10 1919 Mrs E Leftwich  
 REGISTRAR

**21 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 1919

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 to June 29 1929  
 that I last saw him alive on June 27 1929 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Metrial Regurgitation  
92 (duration) yrs. mos. ds.  
 CONTRIBUTORY Arteriosclerosis  
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

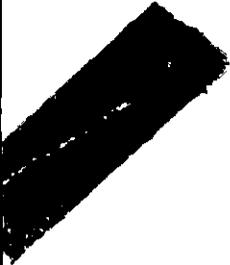
19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) J B Powell M. D.  
 (Address) Longwood Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Mills Chapel DATE OF BURIAL July 19 1919

22. UNDERTAKER Illinois ADDRESS \_\_\_\_\_



D<sup>r</sup>. G. H. Leftwich, pro.  
Beechman,

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Gallatin Registration District No. 673 File No. ....  
 Township Peahts Creek Primary Registration District No. 3-896 Registered No. ....  
 City (No. ....) St. .... Ward) ....

2. FULL NAME John C. Aldridge  
 (a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED Aug 10<sup>th</sup> 1923 Mrs. E. G. Luff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M. D.  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER G. G. Gellespie ADDRESS "Sedalia" Mo.

SUPPLEMENTARY

REGISTRARS - ALL NOT REG. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS DESCRIBED BY LAW

S-25452-A