MAY 25 1934

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

Do not use this space.

Mr. Mc

12536

File No. 151

Registered No.

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township Springfield — Primary Registration District No. 2001

City ..... No. ..... St. ..... Ward)

2. FULL NAME Wm J Aldridge

(a) Residence, No. 615 Mitchell 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1 - 1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	72	10		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Iron Moulder

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

FATHER

13. NAME Reuben Aldridge

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER

15. MAIDEN NAME Parsons Chandler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT Geo Aldridge (ADDRESS) Mount Vernon Mo

18. BURIAL, CREMATION, OR REMOVAL Maple Park DATE April 10 19

19. UNDERTAKER M Schneider (ADDRESS) Springfield Mo

20. FILED 4-10 1934 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-9 , 19 34

22. I HEREBY CERTIFY, That I attended deceased from 4/7, 1934, to 4/8, 1934

I last saw him alive on 4/8, 1934. Death is said to have occurred on the date stated above, at ....m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset 4/7/34

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) O W Maxwell, M. D.

(Address) Springfield Mo

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 Greene — Registration District No. 318

Township — Primary Registration District No. 2001

City Springfield (No. ..... St. ..... Ward)

File No. .....

Registered No. 151

2. FULL NAME Wm J 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
m	w	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.
	71	10	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

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

FATHER

13. NAME .....

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

MOTHER

15. MAIDEN NAME .....

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

17. INFORMANT .....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19....

19. UNDERTAKER .....
(ADDRESS)

20. FILED ..... 19.... Ralph W Langston
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 8, 1934

22. I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. ... THIS IS A PERMANENT ... IANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ... ATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE ... AS PRESCRIBED BY LAW.

5-12936