

No. 2
1-4-41
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13376

Registration District No. 399

Primary Registration District No. 1602

Registrar's No. 1357

1. PLACE OF DEATH:

(a) County. Jackson
(b) City or town. Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(d) Length of stay: In hospital or institution. 12 days
In this community. 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson
(c) City or town. Kansas City
(d) Street No. 2422 Chestnut
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME LOTTIE ALDRIDGE

3. (b) If veteran. name war. No
3. (c) Social Security No. No

4. Sex. Female
5. Color or race. White
6. (a) Single, widowed, married, divorced. Widowed
6. (b) Name of husband or wife. Marshall H. Aldridge
6. (c) Age of husband or wife if alive. Dec 26 - 1854
7. Birth date of deceased. Oct - 26 - 1854

8. AGE: Years 86 Months 5 Days 10 If less than one day

9. Birthplace. St. Joseph Mo

10. Usual occupation. Retired

11. Industry or business.

12. Name. Link Hoodie
13. Birthplace. Unknown
14. Maiden name. Unknown
15. Birthplace. Unknown

16. (a) Informant. Harvey L. House
(b) Address. 2422 Chestnut

17. (a) Burial, cremation, or removal. Buried
(b) Date thereof. Apr. 8 - 41
(c) Place: burial or cremation. Floral Hills Cem

18. (a) Signature of funeral director. A.P. Doehler
(b) Address. 1415 E 13

19. (a) Date received local registrar. Apr. 7 1941
(b) Registrar's signature. M. N. Crow

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th
year 1941 hour 11:00 P.M. minute. M.

21. I hereby certify that I attended the deceased from 3-24-41 to 4-5-41
that I last saw her alive on 4-5-41
and that death occurred on the date and hour stated above.

Immediate cause of death. Rhenmatic heart disease with decompensation

Due to. 95 B

Due to. 95 B

Other conditions. Asthma; cystitis

Major findings: Of operations. Of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Means of injury.

23. Signature. Dr. R. P. Shaw
Address. Med. Dir. K.C. Gen. Hospital
Date signed. 4-7-41

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *H. P. Lochler*

Licensed Embalmer No..... *1166*

P. O. Address..... *1415 E 15*

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 this body is not embalmed, fact should be so stated above.