

FILED OCT 31 1946

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5203^a Ashland Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5203^a Ashland Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Sallie Mae Aldrich**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Leonard L. Aldrich**
6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **Sept. 19 1872**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 0 10 hr. min.

9. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

MOTHER FATHER
11. Industry or business.....
12. Name **George Trittipoe**
13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Ann Compher**
15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Boyd Stone**
(b) Address **5203^a Ashland Ave.**
17. (a) **burial** (b) Date thereof **10-2-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park**
18. (a) Signature of funeral director **Drehmann-Harral**
(b) Address **1905 Union Blvd.**
19. (a) **SEP 30 1946** (b) **J.F. Bedrick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **Sept** day **29**
year **1946** hour **5** minute **30** A.M.
21. I hereby certify that I attended the deceased from **Sept. 4,** 19 **46** to **Sept. 28,** 19 **46**
that I last saw h. **er** alive on **Sept. 28,** 19 **46**
and that death occurred on the date and hour stated above.
Immediate cause of death **Chronic endo-carditis and myocarditis.**

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)
Major findings:.....
Of operations.....
Of autopsy.....
92^a

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

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?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place).....
While at work?..... (e) Means of injury.....
23. Signature **C.H. Gost** (M. D. or other) **MD**
Address **3807 M. Blvd.** Date signed **9/30/46**

NOV 1 1954

2807 N. Grand
No. 5737

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..... *Albert R. Thompson Jr*

∴ Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8393

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Sallie Mae Aldrich

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased 9 - 19 - 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 0 10 _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 9-30-46

19. (a) _____ (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 29
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged etiologically.

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? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

OCT 14 1946

31504