

UR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-046668

FILED VS JAN 25 1960

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Primary Registration District No. 3012

Registrar's No. 121

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>	Length of stay in 1b <b>10 yrs.</b>	c. CITY OR TOWN <b>Excelsior Springs</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Excelsior Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>809 St. Louis Ave.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bell</b> Last <b>Aldrich</b>			4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1959</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>Huntsville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>William Henge</b>	13b. MOTHER'S MAIDEN NAME <b>Minervia Bryan</b>	14. NAME OF HUSBAND OR WIFE <b>Ben Aldrich</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>491-32-2958</b>	17. INFORMANT <b>Mr. S. Andrew Aldrich, R#1, Excelsior Spgs</b>	Address <b>Missouri</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 hrs</b>
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	
	DUE TO (c) <b>Arteriosclerosis</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Active duodenal ulcer</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>6:40</b> Month <b>May</b> Day <b>1950</b> Year <b>1950</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Excelsior Springs, Mo.</b>	COUNTY <b>Clay</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>May 1950</b> to <b>31 Dec. 59</b> and last saw her alive on <b>31 Dec. 59</b> Death occurred at <b>6:40 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>George E. Anderson M.D.</b>	22b. ADDRESS <b>Excelsior Springs, Mo.</b>	22c. DATE SIGNED <b>1-4-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LaPlata</b>	23d. LOCATION (City, town, or county) (State) <b>LaPlata, Missouri</b>
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24. FUNERAL HOME OR ADDRESS <b>Richard Funeral Home, Excelsior Springs, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>1-10-60</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Helix Springs, Va

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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