

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE  
 IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 19 1960

60-037098

INDEXED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 165 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived, or institution; Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Marshall</u>		Length of stay in <u>3 weeks</u>		c. CITY OR TOWN <u>Nelson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon's Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR-DENAIN-ALDREDGE</u>				4. DATE OF DEATH Month Day Year <u>Sept. 9, 1960</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 13, 1989</u>		9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>			11. BIRTHPLACE (City and state or country) <u>Nelson, Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>John Aldredge</u>				13b. MOTHER'S MAIDEN NAME <u>Lisa Sowers</u>				14. NAME OF HUSBAND OR WIFE <u>Grace Yager</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grace Aldredge, Nelson, Mo</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Cowray Thrombosis</u>		DUE TO (c) <u>Arteriosclerotic Vas Disease</u>		15 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							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						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year											
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		COUNTY		STATE			
21. I attended the deceased from <u>Aug 29</u> to <u>Sept 9</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Sept 9</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>B.T. Campbell M.D.</u> (Degree or title)						22b. ADDRESS <u>Marshall Mo</u>			22c. DATE SIGNED <u>9/9/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept. 11, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berea Ceme</u>			23d. LOCATION (City, town, or county) <u>Nelson, Mo.</u> (State)						
24. FUNERAL DIRECTOR <u>Hays - Painter, Petat Home</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9-11-60</u>		26. REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 24 1960

SEP 23 1960

**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 Robert L. Gaunt

Licensed Embalmer No. 406  
P. O. Address Pilot Pro

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.