

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County La Fayette
Township Middletown
or Waverly
Village
or
City

Registration District No. 460

File No.

37786

Primary Registration District No. 4278

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Oliver Henry Albright

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

DATE OF BIRTH

Dec 12, 1839
(Month) (Day) (Year)

AGE

75 yrs. 11 mos. 24 ds.

IF LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Carpentering

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

BIRTHPLACE

(City or town, State or foreign country)

New Philadelphia, Ohio

NAME OF FATHER

Henry Albright

BIRTHPLACE OF FATHER

Penn.

MAIDEN NAME OF MOTHER

Margaret Wink

BIRTHPLACE OF MOTHER

Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Albright

(ADDRESS)

Kansas City, Mo

Filed

Dec 6, 1910

G. B. Williamson

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 5, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 5, 1910, to Dec 5, 1910, that I last saw him alive on Dec 5, 1910, and that death occurred, on the date stated above, at 6:30 p

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

109

Contributory Septicemia

(Signed) E. L. Johnston M. D.

12-6, 1910 (Address) Waverly Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Mattew Bend Mo

DATE OF BURIAL

Dec 8, 1910

UNDERTAKER

G. R. Landrum

ADDRESS

Waverly Mo

PLACE OF DEATH

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

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____ St. _____ Ward _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)		
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION _____

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town,
State or foreign country)

NAME OF
FATHER

BIRTHPLACE
OF FATHER
(City or town, State or foreign country)

MAIDEN NAME
OF MOTHER

BIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) 191 _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____,

that I last saw h. _____ alive on _____, 191 _____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

191 _____ (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191 _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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