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

Do not use this space.

B 7 21373

1. PLACE OF DEATH
County Jackson Registration District No. 399 Hospital File No.
Township Kaw Primary Registration District No. 1 Registered No. 2718
City K C Mo (No. 5223 Wilburn Court St. Ward)

2. FULL NAME Mary Albertson
(a) Residence. No. 5223 Wilburn Court St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe
4. COLOR OR RACE Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 10 - 1918

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
8	8	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Wm Patrick Albertson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Ackerman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Nebr
(STATE OR COUNTRY)

14. INFORMANT William P. Albertson
(Address) 5223 Wilburn Court

15. FILED 7/8, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental - Fractured Right femur - Auto Traumatism.
210 M (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) In K C Mo (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Chas S Wilson, M. D
7-7, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Liberty Nebr
DATE OF BURIAL July 9 - 1927

20. UNDERTAKER Mrs. C. L. Foster
ADDRESS K. C. Mo.

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.