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

Do not use this space.

37761

File No. 53

Registered No. 6

1. PLACE OF DEATH
County Maries
Township Jackson
City (No. , St. , Ward)
Registration District No. 542
Primary Registration District No. 5731

2. FULL NAME Grace Margaret Albertson

(a) Residence. No. 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word):
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18 - 29
7. AGE — YEARS: — MONTHS: — DAYS: 6 — If LESS than 1 day, hrs. or min.:
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN):
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Wm Albertson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Maries Co Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Bessie May Rider
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY) Maries Co Mo

14. INFORMANT Wm Albertson
(Address) Argyle Mo
15. FILED Jan 4" 30 Lorenzo W Eads REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 1929
17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Nov. 25, 1929, that I last saw h. er alive on Nov. 25, 1929, and that death occurred, on the date stated above, at 12:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Capillary Bronchitis
INT B
10 B 10 02
(duration) yrs. 6 mos. da.
CONTRIBUTORY (SECONDARY) Don't know, except cold.
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Place of death.
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) J. J. Rademacher, M. D
(Address) Argyle Mo

*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: Vienna Cemetary — DATE OF BURIAL: Nov 26 1929
20. UNDERTAKER: Henry Hefte — ADDRESS: Vienna 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 very important.