

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

Do not use this space.

12748

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kear Primary Registration District No. 1002  
 City Kansas City (No. Kansas City Genl Hosp) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 1575  
 Registered No. \_\_\_\_\_

**2. FULL NAME** George Albridge

(a) Residence. No. 1428 Wyandale 1 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 16 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>70</u>	<u>1</u>	<u>29</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Carpenter  
 (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) West Virginia

PARENTS	10. NAME OF FATHER <u>George Albridge</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>Caroline Duffield</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Virginia</u>	

14. INFORMANT De Wallace  
 (Address) K.C. General Hosp

15. FILED 4/17, 1930 M. M. Cerave  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-15 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-13, 1930, to 4-15, 1930 that I last saw him alive on 4-15, 1930 and that death occurred, on the date stated above, at 8:30 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Subar Pneumonia  
10.8  
11.0 A  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Empyema  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Gen'l Post + Autopsy  
 (Signed) P. E. Williams, M. D.  
4-15, 1930 (Address) Suprt KC Genl Hosp

\*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 Leeds DATE OF BURIAL 4-17-30

20. UNDERTAKER O. H. Mast ADDRESS 1915 2/5

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

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.

RESERVED FOR BINDING

