

No. 2
-12-40
-17-39
K23155

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34861**
Registrar's No. **1128**

Registration District No. **85** Primary Registration District No. **1001**

1. PLACE OF DEATH
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution **Mo. Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
In this community **76 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN ALBUS**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of deceased's wife **Clara Hanssen Albus** 6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **October 4 1860**
(Month) (Day) (Year)

8. AGE: Years **80** Months **0** Days **18**
If less than one day hr. min.

9. Birthplace **Leavenworth Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Insurance**

11. Industry or business

12. Name **John Albus**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Kessler**
15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Leon H. Albus**
(b) Address **Pittsburg, Kansas**
17. (a) **burial** (b) Date thereof **10-24-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Mora**

18. (a) Signature of funeral director **Fleeman & Son, Inc.**
(b) Address **1946 Colhoun St., city**
19. (a) **Oct 24-1940** (b) **H. S. Causal**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **Saint Joseph, Missouri**
(If outside city or town limits, write "RURAL")
(d) Street No. **728 North 22nd Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **22**
year **1940** hour **9** minute **30** P.M.

21. I hereby certify that I attended the deceased from **April 10**, 1940, to **Oct. 22**, 1940.
that I last saw him alive on **Oct. 22**, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocarditis chronic.
Coronary heart failure.
Due to **Hypertension chronic.**
Phlebotomy obstruction.
Due to **arterio-sclerosis.**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy **No.**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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While at work? (Specify type of place) (e) Means of injury
23. Signature **H. S. Causal** (M. D. or other)
Address **St. Joseph, Mo.** Date signed **10-23-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.