

X23159
FILED MAR 21 1941

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home Smith
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Two days specify whether
 In this community 55 years, months or days

3. (a) PRINT FULL NAME Anna A. Albright3. (b) If veteran,
name war L3. (c) Social Security
No. NONE4. Sex female 5. Color or
race white 6. (a) Single, widowed, married,
divorced married6. (b) Name of husband or wife Lawrence A. Albright 6. (c) Age of husband or wife if
alive 64 years7. Birth date of deceased July-18-1883
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
57 5 17 hr. min.9. Birthplace Mo (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name John Farr13. Birthplace Don't know (State or foreign country)14. Maiden name Priscilla Farr15. Birthplace Don't know (State or foreign country)16. (a) Informant L. O. Albright(b) Address Pampa, Texas17. (a) Burial (Burial, cremation, or removal) (b) Date there Mar 5-1941
(Month) (Day) (Year)(c) Place: burial or cremation Mount Taber18. (a) Signature of funeral director A. J. Christie(b) Address La Plata, Mo.19. (a) Mar. 6/41 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
 (c) City or town La Plata, Missouri
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th
year 1941 hour 12 minute 05 A. M.21. I hereby certify that I attended the deceased from March
3rd, 1941, to March 4th, 1941,
that I last saw her alive on March 3, 1941,
and that death occurred on the date and hour stated above.Immediate cause of death: acute nephritis Duration 3 daysDue to Chronic myocardial lesions 2 weeks

Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations NoneOf autopsy None

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) XXXX(b) Date of occurrence XXXX(c) Where did injury occur? XXXX
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

3 While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature E. S. Smith (M. D. number) 0
Address E. S. Smith, M. D. Date signed 3-4-41

93R

RECEIVED

District Health Officer No. 10

District File Number 2-41-631

Date Filed MAR 19 1947

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.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
SAN FRANCISCO

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6096
Do not use this space.

PLACE OF DEATH

(a) County Adair Registration District No. 1
 (b) Township Kirkville Primary Registration District No. 1 Registered No.
 (c) City Kirkville (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

anna a albright
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>57</u>	<u>5</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 4 1941

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

acute nephritis
not known
Chronic Myocardial lesions

Date of onset 3/10/41

Other contributory causes of importance:

Babert admitted in Coma
no history obtainable

Name of operation Date of

What test confirmed diagnosis? 137 Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) E. S. Smith M. D.

(Address) Kirkville Mo

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-609b