

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

11845

Registration District No. 157

Primary Registration District No. 3036

Registrar's No. 49

1. PLACE OF DEATH:

- (a) County St. Charles
 (b) City or town St. Charles
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph's Hospital
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT
FULL NAMEMary Albert3. (b) If veteran,
name warNo3. (c) Social Security
No.None4. Sex Female5. Color or
race White6. (a) Single, widowed, married,
divorced married

6. (b) Name of husband or wife

George Albert6. (c) Age of husband or wife if
alive 57 years

7. Birth date of deceased

July
(Month)3
(Day)1897
(Year)

8. AGE:

Years

Months

Days

If less than one day

4382

hr.

min.

9. Birthplace

Siles
(City, town, or county)Mo. 1
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Douglas Bibb

13. Birthplace

Lincoln County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name

Mary Scott

15. Birthplace

Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant

Brother James Bibb

(b) Address

Siles, Mo.

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Mar. 7-1941
(Month) (Day) (Year)

(c) Place: burial or cremation

Siles, Mo.

18. (a) Signature of funeral director

William Womum

(b) Address

Siles, Mo.

19. (a)

3-6-41
(Date received local registrar)

(b)

Clarence D. Kessler
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Lincoln
 (c) City or town Siles
 (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 4
year 1941 hour 1 minute 15 A.M.21. I hereby certify that I attended the deceased from March
3 1941 to March 4 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

Respiratory failure

Due to

Intestinal obstruction

Duration

4 days

Due to

Toxemia due to
abstraction3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations NoneOf autopsy not done

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) _____
 (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?
675

While at work

(Specify type of place)

(e) Means of injury

23. Signature Ben H. Bradley (M. D. or other)
Address St. Joseph's Hospital Date signed 3-11-41
St. Charles, Mo.

12212

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.....

Albert G. Hoff

Licensed Embalmer No. 2971

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11845

Registration District No. 757

Primary Registration District No. 2036

Registrar's No. 49

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Mary Albert

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex 7

5. Color or
race W

6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:

Years

Months

Days

If less than one day

43

8

2

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Respiratory failure Duration _____

Due to Intestinal Obstruction

Due to Toxemia due to ob-
struction

Other conditions (last to pregnancy within 3 months of death)

Mechanical Obstruction
Major findings Due to adhesions
Of operation from previous operation

Of autopsy _____ Underlying cause to which death should be charged statistically.

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Ben H. Bradley (M. D. or other)
Address John Leonard Wood Date signed July 11
mo.

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

SUPPLEMENT 12782

11845