

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27303  
Registrar's No. 2961

Filed SEP 12 1941  
Registration District No. 397

Primary Registration District No. 100

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K. C. General  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... 40 Years  
years, months or days)

3. (a) PRINT FULL NAME BESSIE ALBERT  
3. (b) If veteran, name war..... No  
3. (c) Social Security No..... No

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife..... Frank Albert  
6. (c) Age of husband or wife if alive..... 61 years  
7. Birth date of deceased. April 8, 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 3 25  
hr. min.

9. Birthplace..... Nebraska  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER { 12. Name Selah

13. Birthplace No Record  
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Albert

(b) Address 2201 Bales

17. (a) Burial (b) Date thereof 8/6/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 8/1/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 2201 Bales  
(If rural, give location)  
(e) Citizen of foreign country?..... 0 (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 8-2-41  
year..... 41 hour..... minute..... 9:40 M.

21. I hereby certify that I attended the deceased from.....  
....., 19....., to....., 19.....;  
that I last saw him on....., 19.....;  
and that death occurred on the date and hour stated above.  
In immediate cause of death.....

Pontine cerebral hemorrhage  
Injury by fall  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy..... Yes

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 7-31-41 123  
(c) Where did injury occur? H.C. mo  
(City or town) (County)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Yes on highway  
While at work?..... Means of injury.....  
23. Signature Walter M. Crowe (M. D. or other) 3  
Address K.C. Mo Date signed.....

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*J. Edwin Sheppard*

Licensed Embalmer No. 4579

P. O. Address No. 6 - 1st

**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.**