DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31137

FILED OCT 8 1942 294

Registration District No. 20

Primary Registration District No. 3056

Registrar's No. 168

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly Morrow Tp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCormick's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs (Specify whether)
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Macon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Wm M. Albright
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna M. Albright
6. (c) Age of ~~husband or~~ wife if alive 51 years
7. Birth date of deceased August 8 1883 (Month) (Day) (Year)
8. AGE: Years 59 Months 0 Days 24 If less than one day hr. min.
9. Birthplace Macon Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name Henry Albright
13. Birthplace Ohio (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Clara Vansickle
15. Birthplace ~~Boonville~~ Macon Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs Wm Albright
(b) Address Macon, Mo. R 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-42 (Month) (Day) (Year)
(c) Place: burial or cremation Friendship Cem.
18. (a) Signature of funeral director Stephens & Goodding
(b) Address Macon, Mo.
19. (a) Sept 11-42 (Date received local registrar) (b) Irma Rowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1 year 1942 hour 9 minute 15 P.M.
21. I hereby certify that I attended the deceased from 9-1-42, 19..., to 9-1, 1942 that I last saw ~~him~~ alive on 9-1-42, 19... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Obstruction of bowels	
Due to acute appendicitis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations acute appendicitis causing obstruction of bowels
Of autopsy

PHYSICIAN — Underline the 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature T. L. McCormick (M. D. or other)
Address Moberly Mo. Date signed 9-1-42

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 — 1 X19511

RECEIVED
District Health Officer No. 10
District File Number 10-42-1838
Date Filed OCT 7 1942

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 H W Goodding, Registered Apprentice No. ....., working under my personal supervision.

Signed H W Goodding

Licensed Embalmer No. 17501

P. O. Address Atlanta Mo

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.

S. No. 2B
0M—8-21-41
I X29288

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

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STANDARD CERTIFICATE OF DEATH

State File No. 31137

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 168

1. PLACE OF DEATH:

(a) County: Randolph

(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: wm m Albright

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased: aug (Month) 8 (Day) 1883 (Year)

8. AGE: Years 59 Months 0 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month sept Day 1 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY