

FILED AUG 5 1943
Registration District No. 35 42

Primary Registration District No. 1001 1000

State File No. _____

Registrar's No. 725

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 10 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Maryville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1943 hour 7:30 minute A M.
21. I hereby certify that I attended the deceased from June 21 1943 to July 1 1943
that I last saw her alive on July 1 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Saper Pneumonia (Bilateral)
Due to Brain Tumor

Duration

Other conditions (Include pregnancy within 3 months of death)
Due to Brain Tumor

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Georgie Albright

3. (b) If veteran, name war. _____ 3. (c) Social security? No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife R.B. Albright 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown 1890 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>-</u>	<u>-</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Unknown
FATHER { 13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant R.B. Albright
(b) Address Maryville, Mo
17. (a) B (b) Date thereof 7-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation K.C. Mo

18. (a) Signature of funeral director C.L. Foster
(b) Address Kansas City Mo
19. (a) 7-1-43 (b) Rose Dejean
(Date received local registrar) (Registrar's signature)

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 State Hosp. # 2 (Specify type of place) (e) Means of injury _____
23. Signature R.B. Dejean (M. D. or other) MD
Address State Hosp. # 2 Date signed 7-1-43

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

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..... *R. H. Runnels*.....

Licensed Embalmer No. *3860*

P. O. Address *1318 E. 28th St. Kansas City, Mo.*
With Mrs. C. K. Porter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to copy the above constitutes grounds for revocation of license.)

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

State File No. _____
Registrar's No. 725

Registration District No. 42 Primary Registration District No. 1006

1. PLACE OF DEATH
(a) County Buchanan
(b) City or town St Joseph
(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 _____ (Specify whether
years, months or days)

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 George Albright
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 1 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Supernat. Lab. Myocardia Bilateral

4. Sex M 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 _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Due to _____
Due to Brain Tumor (Benign)

8. AGE: Years 53 Months _____ Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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) _____ (e) Means of injury _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

23. Signature R B T Swearing (M. D. or other) me
Address St Joseph Mo Date signed _____
State Hospital

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

SUPPLEMENTARY

MOTHER, FATHER

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

S-24318