DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 7 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4605

Registration District No. 3 3 V

Primary Registration District No. 6 1 1 2 B.

Registrar's No.

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.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Illmo (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 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott 100
(c) City or town Illmo, Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓ 0

3. (a) PRINT FULL NAME Pauline Frances Albrecht
3. (b) If veteran, name war ✓
3. (c) Social Security No. —
4. Sex F - 1
5. Color or race W -
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John W Albrecht
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased April (Month) 23 (Day) 1877 (Year)

8. AGE: Years 66 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Illmo (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Housewife
11. Industry or business

MOTHER
12. Name C. Martin Bohnhardt
13. Birthplace Illmo (City, town, or county) Mo (State or foreign country) 0

FATHER
14. Maiden name Henrietta Ruebel
15. Birthplace Fornfelt (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant John W Albrecht
(b) Address Illmo R1 Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-44 (Month) (Day) (Year)
(c) Place: burial or cremation Luthern - Illmo, Mo
18. (a) Signature of funeral director Bisplinghoff Mubbard
(b) Address Illmo, Mo
19. (a) Jan 24-44 (Date received local registrar) (b) S. T. Nunn (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 20
year 1944 hour 2 minute 4:30 P.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.

	Duration
Immediate cause of death Fractured Femur & Loss of Blood ✓	
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: ✓ 100
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence January - 19 - 1944
(c) Where did injury occur? Illmo Scott Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Railroad Yards Illmo (Specify type of place)
While at work? (e) Means of injury

23. Signature Charles Poe Jr (M.D. or other)
Address Sikeston Mo Date signed 1/24/44

927

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

District Health Office No 2, St. Louis

State File No. 244-5

District File Number

Registrar's No. 2-3-44

Date Filed

Registration District No. ..... Primary Registration District No. .....

1. **PLACE OF DEATH:**

(a) County .....

(b) City or town ..... (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 .....

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

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 ..... (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
FEB 10 1944			..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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 ..... day ..... year ..... 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.

	Duration
Immediate cause of death	
.....	
.....	
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:

(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 ..... (M. D. or other)

Address ..... Date signed .....

M. 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.

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

I X2716?

. No. 2B
M—5-43
P I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ..... FEE

Registration District No. 230 Primary Registration District No. 6112/3 Registrar's No. .....

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Illmo

(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 Pauline F. Albrecht

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

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 April (Month) 28 (Day) 1877 (Year)

8. AGE: Years 66 Months 6 Days 26 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 .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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 January day 20 year 1944 hour 11 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 Fracture skull Duration Loss of blood

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 169-8

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:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence January 20 - 1944

(c) Where did injury occur? Rail Road Yards Illmo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Rail Road Yards Illmo (Specify type of place)

While at work? (e) Means of injury? Struck by train

23. Signature ..... (M. D. or other)

Address 210 E. Kathleen Sikeston Date signed 1/21/44

SUPPLEMENTARY

4005