

FILED DEC 12 1944

Registration District No. **47**

Primary Registration District No. **3008**

14  
1  
2

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether in this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson **14**

(c) City or town Kansas city **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. General Hosp.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALICE ALBERTS

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13  
year 1944 hour 5 minute 35 P. M.

21. I hereby certify that I attended the deceased from Oct 28 1944 to Nov 13 1944  
that I last saw her alive on Nov 13 1944  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased D.K.  
(Month) (Day) (Year)

Immediate cause of death Post operative splenecomy

Due to Supra removal ovarian tumor **11-9-44**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 73 Months - Days -  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings: Ovarian tumor

Of operations Ovarian tumor

Of autopsy Chronic interstitial nephritis, cerebral glioma.

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

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name D.K.

13. Birthplace D.K.  
(City, town, or county) (State or foreign country)

14. Maiden name D.K.

15. Birthplace D.K.  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Post Hosp. records

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Nov 18-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Hospital Grounds

18. (a) Signature of funeral director W. S. Tate

(b) Address 302 Market St. Fulton, Mo.

19. (a) Nov. 18-1944 (b) Joan Morscheckhoff  
(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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature R. S. Tate (M. D. or other) \_\_\_\_\_  
Address State Hosp. #1 Date signed 11-14-44

RECEIVED

District Health Officer No. 9

District File Number

Date Filed 12-11-44

**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**