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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1945

Registration District No. 147

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5037

Primary Registration District No. 1002

Registrar's No. 645

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Hrs (Specify whether
In this community 27 Yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 2846 Wenzel
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillian Albright

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Femal 1

5. Color or race Whute

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife James Albright

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased March 28 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	10	9	hr. min.

9. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name James Whiles
13. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Ellen Sumter
15. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Frank C. Albright
(b) Address 2618 East 9 St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington Cem.

18. (a) Signature of funeral director Mrs C. L. Forster
(b) Address 918 Brooklyn

19. (a) 2-9-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb. 7 1945
year 1945 hour 6 minute 15P M.

21. I hereby certify that I attended the deceased from Coroney, 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 Coronary occlusion	
Due to Arterio-sclerosis	
Due to 94 W	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations History & Inspection
Of autopsy no

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 James Walker 3 (M. D. or other) Crane
Address 1424 Pine Bldg Date signed 2-8-45

(Licensed Embalmer's Statement on Reverse Side)

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.