

Primary Registration District No. 5991

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

1. PLACE OF DEATH:
(a) County Putnam
(b) City or town Rural, Liberty Tmp.
(c) Name of hospital or institution: Mendota, Mo.
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life. years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Putnam
(c) City or town Rural
(d) Street No. Mendota, Mo. R. F. D.
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dianna Belle Albee
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced 2 W.
6. (b) Name of husband or wife Geo. H. Albee 6. (c) Age of husband or wife if alive no years
7. Birth date of deceased Sept. 19th, 1854

8. AGE: Years 88 Months 6 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Putnam Co., Mo.

10. Usual occupation Homework

11. Industry or business _____

MOTHER FATHER { 12. Name Hazaril McKinley
13. Birthplace Ken.
14. Maiden name Lucy Jefferes
15. Birthplace Ken.

16. (a) Informant Clarence Albee
(b) Address Owners Grove, Ill.

17. (a) Burial (b) Date thereof 3-23-45
(c) Place: burial or cremation Mendota, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Unionville, Mo.

19. (a) 4-6-45 (b) [Signature]
(Date received local registrar) (Registered Embalmer's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from March 18, 1945, to March 21, 1945, that I last saw her alive on March 18, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremic poisoning
Due to: Chronic glomerular nephritis and myo-carditis
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: [Signature]
Of operations _____
Of autopsy _____

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 _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address [Address] signed [Signature]

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

RECEIVED

District Health Officer No. 10
District File Number 5-45-819
Date Filed MAY 10 1945

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

Paul E. Husted

Licensed Embalmer No.

3384

P. O. Address

Upperville, 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, fact should be so stated above.