

**FILED** AUG 21 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. **3016**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Colo  
(b) City or town Jefferson city mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
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 Mary allen albers

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 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 12 1945  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>6</u>	hr. _____ min. _____

9. Birthplace St. Marys Hospital Jefferson city mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Conrad Albers  
13. Birthplace Keokuk town mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Turehouse  
15. Birthplace St. Thomas mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Conrad albers  
(b) Address St. Thomas mo

17. (a) burial (b) Date thereof August 13 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Thomas mo

18. (a) Signature of funeral director H. H. Thop  
(b) Address meto mo

19. (a) 8-18-45 (b) Durma Richter  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day Aug  
year 1945 hour 6 minute a M.

21. I hereby certify that I attended the deceased from Aug. 12 1945 to Aug 18 1945  
that I last saw her alive on Aug. 18 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
premature child

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

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

Major findings: Of operations 159  
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 J. A. Osment M.D.  
Address Jefferson city mo Date signed 8/18/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

894

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 *H. H. Strope*

Licensed Embalmer No. *2924*

P.O. Address *Meta md*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Sept

Registration District No. 27

Primary Registration District No. 3016

Registrar's No. 183

1. PLACE OF DEATH:

(a) County Colo  
(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Mary Ellen Albers

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 S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 12 (Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

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

12. Name Conrad Albers

13. Birthplace Koltztown MO (City, town, or county) (State or foreign country)

14. Maiden name Margaret Juelhaime

15. Birthplace St Thomas MO (City, town, or county) (State or foreign country)

16. (a) Informant Conrad Albers

(b) Address St Thomas MO

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 9-13-45 (Month) (Day) (Year)

(c) Place: burial or cremation St Thomas, MO

18. (a) Signature of funeral director H. H. Strat  
(b) Address metz MO

19. (a) 8-18-45 (Date received local registrar) (b) Norma Richter (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Colo  
(c) City or town St. Thomas (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1945 hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug 12 to Aug 18, 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death Premature child  
7 MONTHS

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

Major findings: 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 J. B. Ossman (M. D. or other) M.D.  
Address Jefferson City, MO Date signed 8-28-45

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

8-27-45

CERTIFICATE

STANDARD

PRELIMINARY

S-27167