

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34420**

FILED NOV 12 1946

Registration District No. **2888**

Primary Registration District No. **6-961**

Registrar's No. **23**

1. PLACE OF DEATH

(a) County **Platte**
(b) City or town **East Leavenworth mo RFD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **none**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether years, months or days)
In this community **86 years**

3. (a) PRINT FULL NAME **Elizabeth Albright**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color of face **white** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Chas Albright** 6. (c) Age of husband or wife if alive **dead** years
7. Birth date of deceased **Sept 18 1859**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 11 11 hr. min.

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

10. Usual occupation **House keeper**

11. Industry or business **Own home**

12. Name **Charles Meas** a. h. **4**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Ann Schmitt**

15. Birthplace **Weston Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Geo Albright**

(b) Address **East Leavenworth mo**

17. (a) **Burial** (b) Date there **Aug 31-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Family Cemetery**

18. (a) Signature of funeral director **Leland H. Foster**

(b) Address **Parkville mo**

19. (a) **Nov 1-46** (b) **Mrs. B. P. H. Rollins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Platte 83**
(c) City or town **Rural RFD**
(If outside city or town limits, write "RURAL")
(d) Street No. **East Leavenworth mo**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29**
year hour **8 10** minute **4** M.

21. I hereby certify that I attended the deceased from **August 26** to **August 29** 19 **46**
that I last saw **or** alive on **August 26** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **5 days**

Due to **Cerebral arteriosclerosis**

Due to **Senility**

Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings: **none**
Of operations

Of autopsy **none**

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) **XXXX**
(b) Date of occurrence **XXXX**
(c) Where did injury occur? **XXX**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
XXX
While at work **XXX** (Specify type of place) (e) Means of injury **(C)**

23. Signature **Jewis C. Calvert** (M. D. or other)
Address **Weston Mo.** Date signed **8/31/46**

DISTRICT HEALTH OFFICE
Cameron, Mo.

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, ~~and~~.....

....., Registered Apprentice No.,
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3451*

P. O. Address. *Parkville 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: