

**FILED NOV 25 1946**  
Registration District No. **28**

Primary Registration District No. **4194**

Registrar's No. **103**

**1. PLACE OF DEATH:**  
(a) County **Sturtevant Albany**  
(b) City or town **Albany**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community **Life time**  
years, months or days) (Specify whether)

**3. (a) PRINT FULL NAME** **Jefferson Thomas Ireland**  
3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex **M. O** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **January 10 1873**  
(Month) (Day) (Year)

**8. AGE:** Years **73** Months **9** Days **25** If less than one day hr. min.

9. Birthplace **Sturtevant Co Mo**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Laborer**

**11. Industry or business**  
12. Name **Thomas Ireland**  
13. Birthplace **Irishman Tenn**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Martha Evans**  
15. Birthplace **Irishman Ky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Bus Ireland**  
(b) Address **Albany Mo**  
17. (a) **Burial** (b) Date thereof **Nov 6-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St. Andrew's**

18. (a) Signature of funeral director **W. H. Hoff**  
(b) Address **Albany Mo**  
19. (a) **Nov 11-1946** (b) **Thomas T. Ireland**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo** (b) County **Sturtevant** **38**  
(c) City or town **Albany** **1**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No..... (If rural, give location) **0**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month **Nov** day **5**  
year **1946** hour..... minute..... M.  
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw h..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart body on Nov-5-1946** **Duration**  
Due to **Heart Condition**  
Due to **No external injury**  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy..... **95C**

**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 **W. H. Hoff** **W. H. Hoff** (M. D. or other)  
Address **Albany Mo** Date signed **11-9-46**

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

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

MOTHER, FATHER

**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, or by me

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

Signed Chifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.**

Registration District No. 120 Primary Registration District No. 4194

1. PLACE OF DEATH:  
(a) County Lentz  
(b) City or town Albany  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Jefferson J Ireland  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

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

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Mo

10. Usual occupation Slater

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_ 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

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

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) Nov 30-40 (Date received local registrar) (b) Horner J. Nicks (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ year 194 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

36625