

FILED APR 1 1947  
Registration District No. **199**

Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:  
St. Luke's Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2.5 min.  
(Specify whether \_\_\_\_\_)

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Jackson

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

(d) Street No. 6901 Spruce  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** RONNIE ALBRIGAT.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days

7. Birth date of deceased Nov. 29 - 1946  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
	<u>4</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation infant

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

**MOTHER FATHER**

12. Name Kenneth W. Albrigt

13. Birthplace Davenport Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Wagon, Ethel Schick

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

16. (a) Informant Jennette Albrigt

(b) Address 6901 Spruce

17. (a) Burial (b) Date thereof Mar 18 - 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blackburn Mo.

18. (a) Signature of funeral director E. G. Minnerich

(b) Address Higginville Mo.

19. (a) 3-16-47 (b) Geraldine Adams  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 16 day March  
year 1947 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from 3-16  
Pathologist to Mar 16, 1947  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
bronchial

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

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

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy pneumonia bronch

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? \_\_\_\_\_

23. Signature E. Schmidt (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
(If D or other)

Address St. Luke's Hosp Date signed 3-16-47

Duration \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death would be charged statistically.

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**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. 1095  
working under my personal supervision.

Signed.....

*W. Meinershagen*

..... Licensed Embalmer No. 1095

..... P. O. Address Hagerstown, 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.**