

FILED MAY 12 1947

Registration District No. 237

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5856

State File No. 14389

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Skidmore, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Frank Albright Home /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME DOC JOSEPH ALBRIGHT

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Belle Albright (Deceased) 6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased May 30 1856
(Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days 1 If less than one day hr. --- min. ---

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

10. Usual occupation Farmer-Retired

11. Industry or business None

12. Name Joel Albright
13. Birthplace North Carolina /
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Holt
15. Birthplace North Carolina /
(City, town, or county) (State or foreign country)

16. (a) Informant Frank S. Albright
(b) Address Skidmore, Missouri

17. (a) Burial (b) Date thereof May 4, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Hillcrest Cemetery

18. (a) Signature of funeral director Price Funeral Home

(b) Address 120 East 1st, Maryville, Mo.

19. (a) 3 47 (b) Bess Holt
(Date received local registrar) (Registrar's signature) 1 10

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway 74
(c) City or town Skidmore 0
(If outside city or town limits, write "RURAL")
(d) Street No. No street address 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1947 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3-1-47 to 5-1-47
that I last saw him alive on 5-1-47
and that death occurred on the date and hour stated above.

Immediate cause of death Semiprobable (with heart decompensation)

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. H. Buxton (M. D. or other)

Address Skidmore, Mo. Date signed 5/3/47

MS JUL 12 1966

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

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.