

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28495**
Registrar's No. **179**

Registration District No. **251**

Primary Registration District No. **4384**

1. PLACE OF DEATH:

(a) County **Nodaway**
(b) City or town **Skidmore, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **At Home in Skidmore, Mo.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **FRANKLIN SAMUEL ALBRIGHT**

3. (b) If veteran, * * * * * 3. (c) Social Security No. * * * * *

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lola Albright** 6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **August 17, 1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 11 24 - hr. - min.

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

10. Usual occupation **Farmer & Merchant**

11. Industry or business **None**

12. Name **D. Joseph Albright**
13. Birthplace **Skidmore Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Belle Peters**
15. Birthplace **Savannah, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lola Albright**
(b) Address **Skidmore, Missouri**
17. (a) **Burial** (b) Date thereof **8/13/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hill Crest Cemetery**

18. (a) Signature of funeral director **Phil Thomas**
(b) Address **120 East 1st, Maryville, Mo.**

19. (a) **8-13-47** (b) **Bessie H. Holt**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nodaway**
(c) City or town **Skidmore**
(If outside city or town limits, write "RURAL")
(d) Street No. **None** (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 **August** day **11th.**
year **1947** hour **12** minute **00 Noon**

21. I hereby certify that I attended the deceased from **June 1946** to **August 1947**,
that I last saw him alive on **August 4, 1947**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Colon with metastases to liver**

Due to

Due to

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

Major findings: Of operations **Carcinoma of sigmoid colon, large colon**
Of autopsy

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)
(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? (c) Means of injury

23. Signature **D. A. Blum** (M. D. or other)
Address **Maryville Mo** Date signed **8-12-47**

NOV 17 1953

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.....

Clara M. Price

Licensed Embalmer No.....

1822

P. O. Address.....

Marionville, 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.