

No. 2
1-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39220**

FILED DEC 4 1947

Registration District No. **281**

Primary Registration District No. **2968**

Registrar's No. **61**

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Halfway
(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 _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk **84**

(c) City or town Halfway **9**
(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 _____

3. (a) PRINT FULL NAME Charles Wesley Albert

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21
year 1947 hour _____ minute _____ M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Feb. 7 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 16, 1947
to Nov 21, 1947
that I last saw him alive on Nov 18, 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

69 9 14 hr. _____ min.

Immediate cause of death: Cerebrovascular thrombosis **5809**

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

Due to _____

Due to _____

10. Usual occupation retired farmer

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

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name William Albert

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

14. Maiden name Mary E. Roberts

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

16. (a) Informant Mrs Lula Carter

(b) Address Rt. 4, Bolivar, Mo.

17. (a) burial (b) Date thereof Nov. 22, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethel Cemetery

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

(b) Address Bolivar, Mo.

19. (a) Nov 28, 1947 (b) Ralph Gorden
(Date received local registrar) (Registrar's signature)

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) (b) Means of injury _____

23. Signature J. H. Bridges (City or other) _____

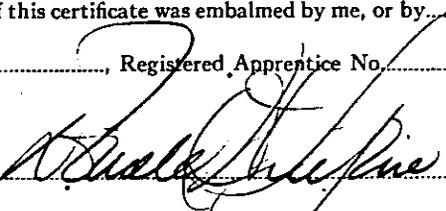
Address Bolivar, Mo Date signed _____

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

RECEIVED
DISTRICT HEALTH OFFICER NO. 7,
DISTRICT FILE NUMBER 11-47-1392
Date Filed 12-3-47

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..... 3053
P. O. Address..... Bolivar, 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.