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7-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 17 1948

Registration District No. **227**

Primary Registration District No. **5806**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Madison Monroe**

(b) City or town **Rural Molino**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
H. #1 Molino
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **43 years**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Monroe** **69**

(c) City or town **Rural Molino**
(If outside city or town limits, write "RURAL")

(d) Street No. **H. #1**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Estla L. Albright**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **F** 5. Color or race **W**

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

6. (b) Name of husband or wife **Pete Albright**

6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **Aug. 20, 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	9	10	hr. _____ min.

9. Birthplace **Peruvia, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Nathan Daniel**

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

14. Maiden name **Sarah Davis**

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

16. (a) Informant **Pete Albright**

(b) Address **Molino, Mo.**

17. (a) **Burial** (b) Date thereof **6/1/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Mexico, Mo.**

18. (a) Signature of funeral director **Cloro Amos**

(b) Address **Mexico, Mo.**

19. (a) **7-7-48** (b) **Elbert Baker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **30**
year **1948** hour **11** minute **45** P. M.

21. I hereby certify that I attended the deceased from **June 20, 1948** to **May 30, 1948**
that I last saw h. or alive on **May 30, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **6 days of Longs medication 2 days**

Due to **Cerebral aneurysm & artery embolism**

Due to _____

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

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place) (c) Means of injury **0**

Signature **John E. Brown** (M. D. or other) _____

Address **Perry, Mo.** Date signed **6/1/48**

RECEIVED

District Health Officer No.

District File Number 6-48-11

Date Filed JUN 16 1948

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 Chas. A. [Signature]

Licensed Embalmer No. 3569

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 34

Registration District No. 227

Primary Registration District No. 5806

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Estla L. Albright

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Aug 20 (Month) (Day) (Year)

8. AGE: Years 21 Months 9 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-7-48 (b) Elbert Baker M.D.
(Date received local registrar) (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 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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? _____

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

S-20186