No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26976

FILED SEP 10 1948

Registration District No. ____ Primary Registration District No. ~~5~~ 3041. Registrar's No. 373

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

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution:
119 Daugherly
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ In this community XXXXX-12 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Dallas 61 000

(c) City or town Dawson
(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 No.

3. (a) PRINT FULL NAME Margaret O. Albern

3. (b) If veteran, name war ____

3. (c) Social Security No. UNKNOWN

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

6. (b) Name of husband or wife Albert Albern

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Apr. (Month) 19 (Day) 1884 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18 year 1948 hour 11 minute P M.

21. I hereby certify that I attended the deceased from ✓, 19__, to —, 19__; that I last saw h__ alive on —, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: acute Myocarditis	
Due to:	
Due to: Had a diabetic condition for several years	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings: Of operation: Found dead while sitting in chair at
Of autopsy: Putney home.

Underline the cause to which death should be charged statistically.

8. AGE: Years 64 | Months 3 | Days 29 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business ____

MOTHER / FATHER

12. Name Maurice O'Conner

13. Birthplace New York (City, town or county) N.Y. (State or foreign country)

14. Maiden name Ellen Quigley

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

16. (a) Informant Mrs. Maurice Albern

(b) Address Dale, Iowa

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Violet Hill, Perry, Ia

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon, Mo.

19. (a) 9-4-48 (Date received local registrar) (b) Ruth McNeely (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 8/18/48

(c) Where did injury occur? Macon Macon Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)

While at work? sitting in Chair (e) Means of injury ____

23. Signature Mrs. Edwards, Coroner (or other)

Address Irwin, Mo Date signed 8/19/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-48-152
Date Filed SEP 9 - 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 Arlint S Kennedy

Licensed Embalmer No. 751

P. O. Address Macon Ma

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.

No. 2B
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 200 Primary Registration District No. 304 Registrar's No. 373

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(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 years, months or days)

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

3. (a) PRINT FULL NAME Margaret O Albon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 19 (Month) (Day) 1884 (Year)

8. AGE: Years 64 | Months 3 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 18 1948 year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1948
S-26976