

FILED OCT 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **32620**

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1168</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		c. LENGTH OF STAY (In this place) <u>4 yrs 2 m 26</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Dearborn Mo</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>				d. STREET ADDRESS (If rural, give location) <u>0830</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Martha</u>		b. (Middle) <u>Belle</u>		c. (Last) <u>Albright</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>15</u> (Year) <u>1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1870</u>	
9. AGE (In years last birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13a. FATHER'S NAME <u>Am Jefferson Todd</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Corl</u>		14. NAME OF HUSBAND OR WIFE <u>Thadawed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Nil</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Thomas Todd Dearborn Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Psychotic</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>  <u>4 yrs</u>  <u>4 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <u>no</u> (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4322</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1-</u> , 19 <u>50</u> , to <u>10-15</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>50</u> , and that death occurred at <u>4:02</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Carroll C. Cates</u> (Degree or title)				23b. ADDRESS <u>State Hospital #2 St Joseph</u>		23c. DATE SIGNED <u>10-15-1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10/17/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crescent</u>		24d. LOCATION (City, town, or county) (State) <u>Okla</u>	
DATE REC'D BY LOCAL REG. <u>Oct 21, 1950</u>		REGISTRAR'S SIGNATURE <u>Carl C. Cates</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Newton Bowman Funeral Home - St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 27 1950

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

working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 10th St. Des Moines, Ia.*

**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.