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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Urban 4479  
3074 State File No.

FILED FEB 6 1953  
BIRTH NO. 39888 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 61574 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Sikeston</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Bell City 1000</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>Rural</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mo. Delta Comm. Hosp.</b>			

3. NAME OF DECEASED (First) (Middle) (Last) <b>David Michael Alberson</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 18, 1953</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	
8. DATE OF BIRTH <b>June 17, 1952</b>		9. AGE (In years last birthday) Months Days <b>7 1</b>		10. HOURS OF SLEEP <b>7 1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Advance, Mo</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>David Alberson</b>		13b. MOTHER'S MAIDEN NAME <b>Nadine Saylor</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>David Alberson - Bell City - Rural</b>	

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) <b>Measles?</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>D.O.A.</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>0850</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>E. D. Urban M.D.</b>		23b. ADDRESS <b>Sikeston</b>		23c. DATE SIGNED <b>7-11-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>1-20-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>NEW CITY</b>	
		24d. LOCATION (City, town, or county) (State) <b>MORLEY MO</b>			

DATE REC'D BY LOCAL REG. <b>1-26-53</b>		REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Welsh Funeral Home Sikeston Mo</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 2 1953

RECEIVED

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 253-22

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 Raymond Crews

Signed.....  
Student Embalmer

Licensed Embalmer No. 3467

P. O. Address Seaton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.