

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004528

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 149

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300
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph 0117</u>	
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>119 Mass. Ave.</u>		d. STREET ADDRESS <u>119 Mass. Ave.</u>	
Length of stay in lb <u>40 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Albee</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>1,</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1879</u>	9. AGE (In years and birth day) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
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10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Buyer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Live Stock</u>	11. BIRTHPLACE (City and state or country) <u>Hiamtha, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Herbert A. Albee</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie Shaw</u>	14. NAME OF HUSBAND OR WIFE <u>Velma R. Albee</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>500-361217</u>	17. INFORMANT <u>Velma R. Albee</u>	Address <u>119 Mass. Ave. St. Joseph, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>331X</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>2/1/59</u> to <u>2/1/59</u> and last saw ^{xxx} him alive on <u>2/1/59</u> Death occurred at <u>4:45 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Collis Poundy M.D.</u> (Degree or title)	22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>2/2/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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24. FUNERAL DIRECTOR <u>Clark Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 9 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>
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All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Dr. Collis Poundy M.D.

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~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Plin E. Boman*

Licensed Embalmer No. *4795*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.