

FILED APR 3-1957

## STANDARD CERTIFICATE OF DEATH

8205

STATE FILE NUMBER

Registration District No. 114 Primary Registration District No. 418 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Franklin</u> 0360				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>0360</u>			
b. CITY (If outside limits, give TOWNSHIP only) <u>Boone Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Same</u> 0360		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>At home</u> <u>6 yrs</u>				d. STREET ADDRESS (If institution, give location) <u>At home</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>J.</u> Last <u>Albright</u>			4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1-1870</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Fred Albright</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
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>None</u>		17. INFORMANT <u>Jos Kamler - Sullivan - Mo</u>			
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>ARTERIO SCLEROTIC HEART DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH
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>426C</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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.)				
20c. TIME OF INJURY Hour <u>8:45</u> Month <u>2</u> Day <u>15</u> Year <u>56</u> a. m. <u>A</u> p. m.							
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <u>2/15/56</u> to <u>2-19-57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>2-24-57</u> Death occurred at <u>8:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Kenneth A. O'Neil</u>				22b. ADDRESS <u>Sullivan Mo</u>		22c. DATE SIGNED <u>3/21/57</u>	
23a. BURIAL CREMATION (Specify)	23b. DATE <u>3-23-1957</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Oak Forest</u>		23d. LOCATION (City, town, or county) (State) <u>Gasconade County - Mo</u>			
24. FUNERAL DIRECTOR <u>Charles Jersome</u>			25. DATE RECD. BY LOCAL REG. <u>3/22/57</u>		26. REGISTRAR'S SIGNATURE <u>Thomas A. Humphrey</u>		

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Chute Sasame*

Licensed Embalmer No. *48*

P. O. Address *Blond-1*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.