

FILED JUL 22 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25986

Do not use this space.

1. PLACE OF DEATH

(a) County Phelps Registration District No. 677
 (b) Township Rolla Primary Registration District No. 4423 Registered No. 77
 (c) City Rolla (d) Street No. McFarland Hospital Rolla, Mo.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

416 Bobbie Gene Albertson
 (a) Residence, No. Vienna, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 13 - 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 1 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. school boy
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Vienna, Mo. (STATE OR COUNTRY) D

FATHER 13. NAME Everet Dewey Albertson

14. BIRTHPLACE (CITY OR TOWN) Osaq. County (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Ida Dambach Albertson

16. BIRTHPLACE (CITY OR TOWN) Vienna, Mo. (STATE OR COUNTRY)

17. INFORMANT Mrs. Ida Albertson (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE VIENNA, MO. DATE JUNE 27, 1940

19. FUNERAL DIRECTOR (NAME) W.C. Birmingham (ADDRESS) Vienna, Mo.

20. FILED June 26, 1940 Geo. F. Myers (Address) Vienna, Mo.
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 26, 1940

22. I HEREBY CERTIFY, That I attended deceased from June 25, 1940 to June 26, 1940

I last saw h. i. m. alive on June 26, 1940 Death is said to have occurred on the date stated above, at 8:20 A.M.

The principal cause of death and related causes of importance were as follows:

Accidental self inflicted gun shot wound through the abdomen causing shock.

Other contributory causes of importance: 194

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W.C. Birmingham M. D.
 (Address) Vienna, Mo.

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 722795

Licensed Embalmer No. 3664

Date Filed 72280

P. O. Address Genoa, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25-986**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **677**

Primary Registration District No. **4403**

Registrar's No.

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

1. PLACE OF DEATH

(a) County **Shelby**
(b) City or town **Reed**
(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)

3. (a) PRINT FULL NAME

Robbie Gene Alberston

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widged, married, divorced **s**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive, _____ years

7. Birth date of deceased **May 13, 1932**
(Month) (Day) (Year)

8. AGE: Years **8** Months **1** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Sept 14, 1940** (Date received local registrar) **Joe. F. Ayers** (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH Month **June** day **26**
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.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

