

FILED DEC 3 1943
Registration District No. 128

Primary Registration District No. 5463A

State File No. _____

Registrar's No. 21

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **TURNERS MO**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Greene** **39**
(c) City or town **Turners** **6**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **15th**
year **1943** hour **11** minute **00 P.** M.
21. I hereby certify that I attended the deceased from **Jan 25 1943** to **Nov 15 1943**
that I last saw **her** alive on **Nov 15 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Arteriosclerosis**
Due to: **Arteriosclerosis of Lenes**
Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 **Walter Smith** (M. D. or other) **MD**
Address **Springfield MO** Date signed **11-17-43**

3. (a) PRINT FULL NAME **ROSA ELLIN ALBRIGHT**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **WM E. ALBRIGHT** 6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **March 3 1872**
(Month) (Day) (Year)

8. AGE: Years **71** Months **8** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **NEB. /**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **In home**

12. Name **Jackson Sullivan**

13. Birthplace **Texas /**
(City, town, or county) (State or foreign country)

14. Maiden name **E. Edmondson /**

15. Birthplace **NEB. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Wm E. Albright**

(b) Address **Turners MO**

17. (a) **Burial** (b) Date thereof **Nov. 17-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pleasant Hope Mo. Cem.**

18. (a) Signature of funeral director **J. W. Linguey Co.**
(b) Address **Springfield, MO.**

19. (a) **Nov 15/43** (b) **Harland Harrison**
(Date received local registrar) (Registrar's signature)

1261 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.

Signed.....

Licensed Embalmer No. 4070

P. O. Address.....

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.