

No. 2
 8-43
 5-17-39
 X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33420

State File No. _____

FILED NOV 13 1945

Registration District No. 55

Primary Registration District No. 5011

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
8 N. Hale
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
 (c) City or town Carrollton
(If outside city or town limits write "RURAL")
 (d) Street No. 8 N. Hale
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Wilhelmina Albrecht

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

4. Sex Fe 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Frank Albrecht 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased Oct. 24 1875
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 20 hr. _____ min. _____
If less than one day

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Casper Schroer
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Theresa Jankart
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Albrecht
 (b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof 10-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sacred Heart Cem

18. (a) Signature of funeral director Stanley J. Gibson

(b) Address Carrollton Mo.

19. (a) 10/15/45 (b) Mrs. Harold Cabert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
 year 1945 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from Mon. 1940 to Oct 14 1945
 that I last saw her alive on Oct 14 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheritic P. Leary Duration 30 hrs.

Due to _____

Due to _____

Other conditions High Blood Pressure, Hypertension
(Include pregnancy within _____ months of death)

Major findings: Of operations _____

Of autopsy NO

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) (c) Means of injury

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

Address Carrollton Mo. Date signed 10-15-45

Duration

30 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

1 & 2 & 4

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 11-12-41

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Va

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.