

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 Months
(Specify whether In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 614 No. 7th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James R. Albright

3. (b) If veteran, name war No

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1947 hour 2 minute 20 A. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Madeline Albright

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased August 22 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 7 1947 to Jan 30 1947
that I last saw him alive on Jan 29 1947
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>65</u>	<u>5</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Chronic myelogenous leukemia

Due to Chronic Scurvy arthritis

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

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

10. Usual occupation Salesman

11. Industry or business Scanlan Hdwe. Co.

Major findings: _____

Of operations: 747

Of autopsy: _____

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

MOTHER FATHER { 12. Name William Albright

13. Birthplace Unknown No. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Wright

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

16. (a) Informant Mrs. Madeline Albright

(b) Address St. Joseph, Mo.

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? _____

17. (a) Burial (b) Date thereof 2/ 1/ 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director Heaton Be Sole & Bouhman

(b) Address St. Joseph

While at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature Louis J. Neuboff M.D. (M.D. or other) _____
Address 825 Charles Street Date signed 1/30/47

19. (a) 2-3-47 (b) K. C. Jenkins
(Date received local registrar) (Registrar's signature)

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

REC'D
FEB 24 1947

FEB 20 1947

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, ~~6287~~.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed Raymond W. Morehead

Licensed Embalmer No. 4413 A

P. O. Address 319 So 10th Street

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.