

3-No. 2  
-12-45  
-5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 31 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 10474  
Registrar's No. 2949

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Aug. 25, 1946 1945  
In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Vinnie Albright  
(b) If veteran, name war no (c) Social Security No. 76

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced widow  
(b) Name of husband or wife Joel (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb. 29, 1860  
(Month) (Day) (Year)

8. AGE: Years 87 Months 0 Days 18  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Mrs. NELSON COOK  
13. Birthplace unk. UNKNOWN  
(City, town, or county) (State or foreign country)

14. Maiden name unk.

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

16. (a) Informant City Infirmary-Redords  
(b) Address 5800 Arsenal St.

17. (a) REMOVAL (b) Date thereof 3-19-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation EDWARDSVILLE, ILL.

18. (a) Signature of funeral director Edward H. Happe  
(b) Address 4700 Washington Blvd.

19. (a) MAR 19 1947 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 18  
year 1947 hour \_\_\_\_\_ minute 12:45 p.m.

21. I hereby certify that I attended the deceased from Aug. 25, 1945  
Mar. 18, 1947 19\_\_\_\_, to 19\_\_\_\_;  
that I last saw her alive on Mar. 18, 1947 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro Vascular incident  
probably thrombosis- 4 days-recurrent  
from 1946.

Due to Generalized Arteriosclerosis-1946 Plus.

Due to \_\_\_\_\_

Other conditions\* 83  
(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)  
(b) Means of injury \_\_\_\_\_

23. Signature Palmer P. Bouchard (M. D. unmarked)  
Address Infirmary Date signed 3/18

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

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

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..... *Crest W. Spencer* .....

Licensed Embalmer No..... *4080* .....

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 318Primary Registration District No. 1003Registrar's No. 2949

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town..... ST. LOUIS  
 (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 Vernie Albright

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Feb 27 (Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 0 (If less than one day, hr. min.)

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

10. Usual occupation nil11. Industry or business nil

- MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bredeek (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) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 18  
 year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
 that I last saw him..... 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.....

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

SUPPLEMENTARY

APR 3 1947

10474