

FILED APR 14 1947  
378

State File No. \_\_\_\_\_

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

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

1003

Registrar's No. 3528

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: Barnes Hospital,  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 7 days (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Nemaha 999  
(c) City or town Centralia 14  
(If outside city or town limits, write "RURAL") NR, 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALBERTA MAE DREHER

3. (b) If veteran, name war No (c) Social Security No. 494-30-5504

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 12 1927  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 5 19 hr. \_\_\_\_\_ min.

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

10. Usual occupation Stenographer

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

12. Name Daniel A. Dreher

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

14. Maiden name Grace Amintrout

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

16. (a) Informant Daniel A. Dreher

(b) Address Centralia, Kansas

17. (a) Removal (b) Date thereof 4-1-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Kansas

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 2 1947 (b) J. F. Breeseck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 1  
year 1947 hour 7/30 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from March 24  
1947 to APRIL 1, 1947,  
that I last saw her alive on April 1, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Cerebral Thrombosis?  
Due to Congenital malformation of the heart  
Due to \_\_\_\_\_  
Other conditions Polycythemia I  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy same  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 0  
23. Signature J. F. Breeseck (M. D. or other) \_\_\_\_\_  
Address Barnes Date signed 4-1-47

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

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17  
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**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 *J. W. Wilkinson*  
Licensed Embalmer No. 3575

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.**