

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27822

FILED SEP 2 1949

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State File No. 7370

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>University City</u>                                      |  |
| c. LENGTH OF STAY (In this place)   |  | d. STREET ADDRESS (If rural, give location) <u>W.R. 7327 Shaftsbury Ave.</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>                                |  |  |  |

|   |                               |   |  |   |   |
|---|-------------------------------|---|--|---|---|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) b. (Middle) c. (Last)<br><u>Margaret Elizabeth Albright</u> |                               |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Aug. 24, 1949</u>      |   |   |
| 5. SEX<br><u>F.</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>M.</u> | 8. DATE OF BIRTH<br><u>Apr. 16, 1895</u>                           | 9. AGE (In years last birthday) <u>54</u> | IF UNDER 1 YEAR<br>Months <u>14</u> Days <u>8</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Memphis, Tenn.</u> |   | 12. CITIZEN OF WHAT COUNTRY?                      |

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME<br><u>James O'Brien</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Catherine McArdle</u> | 14. NAME OF HUSBAND OR WIFE<br><u>T. Edw. Albright</u> |
|--|---|--|

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|---|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Mr. T. Edw. Albright, 7327 Shaftsbury Ave.</u> |
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|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 MONTHS</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA OF LIVER</u>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>CARCINOMA OF URINARY BLADDER</u><br>DUE TO (c) <u>—</u> |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>—</u>   |  |  |   |

|                        |  |   |
|------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><u>SAME AS ABOVE</u> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|---|

|  |  |  |
|--|--|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>52</u> |
|--|--|--|

|  |  |  |
|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><u>181 X</u> |
|--|--|--|

22. I hereby certify that I attended the deceased from MARCH, 1948 to Aug. 24, 1949, that I last saw the deceased alive on Aug. 23, 1949, and that death occurred at 8:2 m., from the causes and on the date stated above.

|   |                   |  |                                    |
|---|-------------------|--|------------------------------------|
| 23a. SIGNATURE<br><u>James N. Cummings M.D.</u> | (Degree or title) | 23b. ADDRESS<br><u>424 N. Euclid Av.</u> | 23c. DATE SIGNED<br><u>8-24-49</u> |
|---|-------------------|--|------------------------------------|

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 24b. DATE<br><u>Aug. 26, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u> | 24d. LOCATION (City, town, or county) (State)<br><u>St. Louis, Mo.</u> |
|--|-----------------------------------|---|--|

|  |   |  |                                     |
|--|---|--|-------------------------------------|
| DATE REC'D BY LOCAL REG.<br><u>AUG 24 1949</u> | REGISTRAR'S SIGNATURE<br><u>J. B. Lasater</u> | FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur J. Donnell</u> | ADDRESS<br><u>800 Lindell Blvd.</u> |
|--|---|--|-------------------------------------|

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*W. H. Van Meter*

Licensed Embalmer No. 2825

P. O. Address 4240 Lafayette

**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.