Health, & Welfare Public Service

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FILED JAN 12 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-045359
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12188

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY
b. CITY OR TOWN 915 N.GRAND,ST.LOUIS, MO. Inside Limits Yes [X] No [ ]	c. CITY OR TOWN ST. LOUIS Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL Length of stay in 1b 96 days	d. STREET ADDRESS (If outside, give location) 5374 DELMAR BLVD. Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First HUGH Middle D. Last ALLBRIGHT

4. DATE OF DEATH Month Day Year DECEMBER 17, 1958

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 7/7/87

9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) MARQUAND, MO.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME GEORGE W. ALLBRIGHT

13b. MOTHER'S MAIDEN NAME LEANNAH TINNIN

14. NAME OF HUSBAND OR WIFE NEDRA ALLBRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-I

16. SOCIAL SECURITY NO. 487-22-2921

17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE BLADDER — INTERVAL BETWEEN ONSET AND DEATH 25 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 181.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 9/12/58, to 12/17/58 and last saw ~~XX~~ him alive on 12/17/58
Death occurred at 3:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE ROBERT M. WEISS (Degree or title) M.D.

22b. ADDRESS VAH, ST. LOUIS, MO.

22c. DATE SIGNED 12/17/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 12-19-58

23c. NAME OF CEMETERY OR CREMATORY Christian Cemetery

23d. LOCATION (City, town, or county) (State) Fredricktown, Mo.

24. FUNERAL DIRECTOR Albert H.Hoppe, ADDRESS 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. DEC 17 '58

26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.R.

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Signature of Student Embalmer

Signed G. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.