

FILED VS JAN - 5 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59 044743
STATE FILE NUMBER

Registration District No. 206 Primary Registration District No. 5742 Registrar's No. 64

620
V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <i>Madison</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Madison</i>	
b. CITY OR TOWN <i>Big Creek</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Marquand</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1</i> Length of stay in lb <i>✓</i>		d. STREET ADDRESS (If outside, give location) <i>6 miles South of Marquand</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <i>Nancy Jane Albright</i>			4. DATE OF DEATH Month Day Year <i>Dec 25 1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 7-1867</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <i>92</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <i>Madison Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Wade Sitze</i>		13b. MOTHER'S MAIDEN NAME <i>Catherine Masters Berry</i>	
14. NAME OF HUSBAND OR WIFE <i>E. Albright</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)	
16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT Address <i>Hettie Albright Marquand, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Chronic diabetes mellitus</i> DUE TO (c) <i>arteriosclerotic hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>2 years</i> <i>2 years</i>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>11/25/59</i> to <i>11/25/59</i> and last saw her alive on <i>11/25/59</i> Death occurred at <i>5 p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M. Grooma</i> (Degree or title) <i>MD</i>		22b. ADDRESS <i>Federicktown Mo</i>	
22c. DATE SIGNED <i>12/30/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec-27-1959</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Kinder Chapel Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bollinger Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Glen E. Kinder Lutesville, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>12-30-1959</i>	
26. REGISTRAR'S SIGNATURE <i>Florence Dickel</i>			

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *J. E. Graham*

Licensed Embalmer No. *4010*

P. O. Address *Lutesville,*

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.