

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031249

STATE FILE NUMBER

AMENDED

Filed on 317 Primary Registration District No. 541 Registrar's No. 2271
317 AUG 28 1961

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in lb <u>12 hrs</u>	c. CITY OR TOWN <u>Webster Shores</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis County Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>70 Sandbar Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ALBRIGHT</u> Last <u>ALBRIGHT</u>			4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17 - 1887</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>city of St Louis</u>	11. BIRTHPLACE (City and state or country) <u>St Louis</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>William J. Albright</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Sack</u>
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute anterior myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic coronary thrombosis</u>		
DUE TO (c) <u>arteriosclerotic heart disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign prostatic hypertrophy</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m. Month, Day, Year _____	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 <u>8-10-1961</u> to <u>8-10-1961</u> and last saw <u>him</u> alive on <u>8-10-1961</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Albert L. Howe M.D.</u>	22b. ADDRESS <u>601 S. Brentwood</u>	22c. DATE SIGNED <u>8/11/61</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National J. B. Mo</u>
23d. LOCATION (City, town, or county) <u>St Louis Mo</u>		State _____
24. FUNERAL DIRECTOR <u>Louis A Bopp</u> ADDRESS <u>10610 Mack Ave</u>	25. DATE RECD. BY LOCAL REG. <u>8-12-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Francis J. Myland Jr

Licensed Embalmer No. 4512

P. O. Address Richwood, W. Va.

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.