

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007682

FILED MAR 15 1962

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **2740** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		c. CITY OR TOWN <b>ST. Louis</b>	
Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>3405<sup>2</sup> Postalozzi</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3405<sup>2</sup> Postalozzi</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Morgan</b> Middle <b>Albright</b> Last	4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1962</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 2, 1890</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CAB DRIVER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>PENNSYLVANIA</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>WILLIAM ALBRIGHT</b>	13b. MOTHER'S MAIDEN NAME <b>EMILY SNYDER</b>	14. NAME OF HUSBAND OR WIFE <b>RUTH ALBRIGHT</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>Yes</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>JANE CLAY 6714 PARKWOOD Ph.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> DUE TO (b) DUE TO (c) <b>527.1H</b>	INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>metastatic Carcinoma of Prostate</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **11-1-61** to **3-9-62** and last saw her/him alive on **2-19-62**.  
Death occurred at **12:59 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Phillip Carr MD</b>	22b. ADDRESS <b>Firmin Desloge Hospital</b>	22c. DATE SIGNED <b>3-12-62</b>
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23a. BURIAL, CREMATION REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>MARCH 13, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BRNS Mo</b>
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24. FUNERAL DIRECTOR <b>Thomas Katis 2906 Shawnee</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 12 1962</b>	26. REGISTRAR'S SIGNATURE <b>Don Smith. M.D.</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Glavos

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.