

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

10015

File No. _____
Registered No. 73
St. _____ Ward _____

4 1929 *St. Joseph's Hospital*

1. PLACE OF DEATH
County Cal Registration District No. 213
Township _____ Primary Registration District No. 3014
City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME Edna Raymond Albine
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25, 1914
AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 7 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper County, Missouri

10. NAME OF FATHER Stephen Albion
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cooper County, Mo.
12. MAIDEN NAME OF MOTHER Laura Baughman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cooper County, Mo.

14. INFORMANT S. Albine
(Address) California, Mo

15. FILED 3-16-29 Switzerland REGISTRAR

(2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/11 1929
17. I HEREBY CERTIFY, That I attended deceased from 3/11, 1929 to 3/11, 1929 that I last saw him alive on 3/11, 1929 and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
General peritonitis
121A
124

(duration) yrs. mos. 3 da.
CONTRIBUTORY Refused appendix (SECONDARY)
(duration) yrs. mos. 4 da.

18. WHERE WAS DISEASE CONTRACTED California Mo
IF NOT AT PLACE OF BIRTH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) W. A. Clark M.D.
3/11, 1929 (Address) Jefferson City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jefferson City DATE OF BURIAL May 13 1929

20. UNDERTAKER Switzerland ADDRESS California

CAUSE OF DEATH in plain terms, so that it may be palid. AGE should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. Fully classified.

