

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

Do not use this space.

9248

1. PLACE OF DEATH

County Madison Registration District No. 862 File No. _____
 Township Burdick Primary Registration District No. 6135 Registered No. 8
 City Carrollton St. _____ Ward _____

2. FULL NAME Andrew Jackson Abbott

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 27 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 | 10 | 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer
 (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) unknown

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

14. INFORMANT John Abbott (Address) Kansas City Mo.

15. FILED Feb 13 1929 REGISTRAR G. W. Deob

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-7-29, 1929, to 2-12-29, 1929, that I last saw him alive on 2-7-29, 1929, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Heart
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) [Signature], M. D. _____, 19 _____ (Address) Carrollton

*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 Carrollton DATE OF BURIAL 2-13 1929

20. UNDERTAKER Wayland V. Elliott ADDRESS Carrollton Mo.

107
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 31
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

