

REC'D DEC 12 1938

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

37155

Do not use this space.

791

1008

Registered No. 9482

1. PLACE OF DEATH

- (a) County.....
(b) Township.....
(c) City ST. LOUIS MO. (d) Street No. ST. JOHNS HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

- MICHAEL ABBOTT
(a) Residence, No. 4137^a ST. LOUIS AVE St. 10
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCT 30th - 38, 19

- 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WINEFORD

22. I HEREBY CERTIFY, That I attended deceased from 10/2, 1937 to 10/30, 1938
Last saw him alive on 10/30, 1938. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
- MARCH 17, 1867

to have occurred on the date stated above, at 1:40 P.M.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 7 13

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED CASKET
9. Industry or business in which work was done, as saw mill, bank, etc. TRIMMER
10. Date deceased last worked at this occupation (month and year) 1934
11. Total time (years) spent in this occupation 3.5

Cerebral Resatate Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- ILL

Other contributory causes of importance:

Metastases Pelvic & spine

13. NAME
- MICHAEL ABBOTT

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- IRELAND

15. MAIDEN NAME
- ROSE DUNN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- IRELAND

17. INFORMANT
- MRS J MILLER
-
- (ADDRESS)
- 4137^a ST. LOUIS AVE

18. BURIAL, CREMATION, OR REMOVAL

PLACE CALKARY DATE NOV 2^d, 1938

19. FUNERAL DIRECTOR (NAME)
- Cullen + Kelly
-
- (ADDRESS)
- 1414 North Taylor Ave

20. FILED NOV 1 1938Local Registrar. J. J. Bredeck (Address) 313 N. 9thName of operation Trans-Vulv. Resect Date of 10/28/37What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) J. J. Bredeck, M. D.(Address) 313 N. 9th

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. *131*

P. O. Address *1416 N Taylor*

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 this body is not embalmed, above space should be left blank.