

REC'D MAY 16 1939

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

14683  
Do not use this space.

1. PLACE OF DEATH

(a) County  Cole  Registration District No.  212   
(b) Township  Clark  Primary Registration District No.  5292   
(c) City   (d) Street No.   St.    
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME  130. Galdonia Ann Abbott

(a) Residence, No.   Eugene, Mo. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  July 9th, 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
 73 8 26

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  Missouri

13. NAME  Wakefield Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  Tenn.

15. MAIDEN NAME  Errene Bryant

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  Missouri.

17. INFORMANT  Mrs. Williams  (ADDRESS)  Eugene, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE  Hickory Hill Cem.  DATE  Apr. 6th, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS)  G. N. Steffens   Russellville, Mo.

20. FILED  4/6  19  39   Mr. J. P. Glover  Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)  April 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from  April 4, 1939  to  April 5, 1939   
I last saw her alive on  April 4, 1939  Death is said to have occurred on the date stated above, at  6:00 A.M.   
The principal cause of death and related causes of importance were as follows:

Hemiplegia

Date of onset

Other contributory causes of importance:

Name of operation  Physical  Date of    
What test confirmed diagnosis  Physical  Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?   Date of injury  , 19    
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?    
If so, specify   (Signed)  Geo. H. Shubert , M. D.

(Address)  Eugene, Mo.  19  39

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.

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**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.....

P. O. Address.....

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

14683 7  
Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 212  
(b) Township Clark Primary Registration District No. 3292 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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 Caldonia Ann Abbott

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-5-1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m. The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
73 8 26

Hemiplegia  
Cerebral Hemorrhage  
Date of onset 4/4/39

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

Other contributory causes of importance: gla

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis physical Was there an autopsy? \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

MOTHER 15. MAIDEN NAME \_\_\_\_\_  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) Geo. H. Shirley, M. D.  
(Address) Eugene

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
If any information should be can truly supplied. AGENT. STATE EXAMINER. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every statement of OCCUPATION is very important.

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