

REC'D MAY 22 1939

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

15485

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
(b) Township Masson Primary Registration District No. 3029 Registered No. 126
(c) City Hannibal (d) Street No. Leveering 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

(a) Residence, No. 165 Clara Abrams St. R.R. #1, Huntington, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John W. Abrams</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 11, 1887</u>		
7. AGE YEARS <u>51</u>	MONTHS <u>8</u>	DAYS <u>20</u>
If LESS than 1 day,hra. ormin.		
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. <u>at home</u>	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clay County, Illinois</u>	
	13. NAME <u>James B. Thrash</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clay County, Illinois</u>	
	15. MAIDEN NAME <u>Catherine Marshall</u>	
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>		
17. INFORMANT (ADDRESS) <u>John W. Abrams, Huntington, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Mt. Olive</u> DATE <u>April 3, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Ray P. Stewart, Hannibal, Mo.</u>		
20. FILED <u>April 17, 1939</u> <u>H. C. Thrash</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 11th, 1939, to March 31, 1939. I last saw her alive on March 11th, 1939. Death is said to have occurred on the date stated above, at 11:30 P.M.
The principal cause of death and related causes of importance were as follows:
Post-operative wound infection Date of onset 3/27/39
acute dilatation of stomach 3/29/39

Other contributory causes of importance:
Obesity ?
Hypertensive heart disease ?
Secondary Anemia ?

Name of operation gastrectomy Date of 3/22/39
What test confirmed diagnosis? _____ Was there an autopsy? Yes

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? No
If so, specify _____
(Signed) Narrige M. Green, M.D.
(Address) 125 N. 6th St. Hannibal, Mo.

1956

STATE BOARD OF HEALTH
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
BOSTON, MASSACHUSETTS

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,

Roy P. Schwartz

or by

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

Signed.....

Roy P. Schwartz

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

15-485-
Do not use this space.

1. PLACE OF DEATH
 (a) County Marion Registration District No. 347
 (b) Township _____ Primary Registration District No. 3029 Registered No. 126
 (c) City Hannibal (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 Clara Abrams
 (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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 51 8 20
 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 _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____ Local Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 31 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ 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:
Post operative wound
infection
acute dilatation of stomach
hypertension heart disease
secondary anemia
(Fibroid uterus)
 Other contributory causes of importance: 2958
 Name of operation Hysterectomy Date of _____ 3/25/39
 What test confirmed diagnosis? _____ 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) Harry Remond Greene, M.D.
 (Address) 100 N. 6th St. Hannibal Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important.

