V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10299

Registration District No. 83 Primary Registration District No. 5124 Registrar's No.

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Wallace
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify)
In this community 86 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town Wallace
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME SARAH JANE ABBOTT
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John Abbott
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 15 (Day) 1940 (Year)

8. AGE: Years	Months	Days	If less than one day
86	0	14	hr. min.

9. Birthplace Buchanan county (City, town, or county) Mo. (State or foreign country)
10. Usual occupation housewife
11. Industry or business home

MOTHER FATHER
12. Name James Vestal
13. Birthplace unknown (City, town, or county) N. Carolina (State or foreign country)
14. Maiden name Sarah Williams
15. Birthplace unknown (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Lena Abbott
(b) Address Wallace, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 40 (Month) (Day) (Year)
(c) Place: burial or cremation Turner cemetery
18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address 1946 Calhoun St. Joseph, Mo.
19. (a) 3/30 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 29
year 1940 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from March 23, 1940 to March 28, 1940
that I last saw her alive on March 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Organic Heart Disease	5 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (Specify) Means of injury

23. Signature (M. D. or other)
Address Wallace Mo. Date signed 3-31-40

(Licensed Embalmer's Statement on Reverse Side)

FILED
District Health Officer No. 11
District File Number 440-509
Date Filed APR 10 1940

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 C G Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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.