

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 impor

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29085
Registrar's No. 256

Registration District No. 547 Primary Registration District No. 3079

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal, MO.
(c) Name of hospital or institution: #4 Myers Row
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME HUMPHREY L. ABBEY
8. (b) If veteran, name war World War 3. (c) Social Security No. 486-12-0669

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife ANNA ABBEY
6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased Sept 11th 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 11 16 hr. min.

9. Birthplace Rolla County, MO
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Hannibal Gas Works & Laundry Co.

12. Name Walter Abbey

13. Birthplace Hannibal, MO
(City, town, or county) (State or foreign country)

14. Maiden name Josephine M. Marcellus

15. Birthplace Hannibal, MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature anna abbey

(b) Address HANNIBAL, MO.

17. (a) Burial (b) Date thereof Sept. 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Cemetery

18. (a) Signature of funeral director William Stephens

(b) Address HANNIBAL, MO.

19. (a) 9-5-40 (b) St. C. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Marion
(c) City or town Hannibal, MO.
(If outside city or town limits, write "RURAL")
(d) Street No. #4 Myers Row
(Rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27th
year 1940 hour Five minute thirty a. M.
21. I hereby certify that I attended the deceased from Aug 26, 1940 to Aug 27, 1940
that I last saw him alive on Aug 27-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary thrombosis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration _____
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?
While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature W. C. Fisher (M. D. or other) _____
Address Hannibal, Mo Date signed 9/1/40

23

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 *Geo E Roberts*

Licensed Embalmer No. *2113*

P. O. Address. *1218 Broadway*

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.

Registration District No. **547**

Primary Registration District No. **3029**

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

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(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 whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Humphrey L. Abbey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **39** Months **11** Days **16** If less than one day _____ hr _____ min

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pulmonary Hemorrhage

Due to _____

Due to **Acute Tuberculosis n.m.d.**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature **H** (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

