

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

13860

Registration District No. 73Primary Registration District No. 3006Registrar's No. 90

1. PLACE OF DEATH

- (a) County Boone
 (b) City or town Columbin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Ellis Federal State Cancer Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Fifteen days
 (Specify whether in this community, years, months or days)

3. (a) PRINT FULL NAME

M. H. Abbott3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex Male5. Color of
race White6. (a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife

Laura A. Abbott

6. (c) Age of husband or wife if

alive 34 years

7. Birth date of deceased

July1 (Month) 1887 (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

5392

hr. min.

9. Birthplace

Beldon, Texas

(City, town or county)

(State or foreign country)

10. Usual occupation

Traveling Salesman

11. Industry or business

Salesman

12. Name

M. H. Abbott

13. Birthplace

Texas

(City, town or county)

(State or foreign country)

14. Maiden name

Minnie B. Spears

15. Birthplace

Louisiana

(City, town or county)

(State or foreign country)

16. (a) Informant

Social Service Record

(b) Address

Phone Hospital17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

April 6, 1941

(Month) (Day) (Year)

(c) Place: burial or cremation

St. Vincent's Catholic Cemetery

18. (a) Signature of funeral director

W. J. Brown

(b) Address

703 S. 1st St., St. Louis, Mo.

19. (a)

4/3/41

(Date received local registrar)

(b)

Allice Selby

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Pettis
 (c) City or town Sedalia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 312 East 5th St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
 year 1941 hour One minute 20 P. M.

21. I hereby certify that I attended the deceased from
3-20, 1941, to 4-3, 1941
 that I last saw him alive on 4-3-, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death

1. Lung Abscess
 2. Surgical Shock
 Due to 3. Emphysema

Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:

Of operations Lung Abscess of Rt upper Lobe
 Of autopsy

Duration

8 months

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)

23. Signature W. J. Brown (M. D. or other)
 Address Ellis Federal Cancer Hosp Date signed 4-3-41

1147

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13860

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Boone
(b) City or town Columbia
(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 _____
In this community mother's name given (Specify whether years, months or days) just initials.

3. (a) PRINT FULL NAME

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

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

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

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

8. AGE: Years Months Days If less than one day
53 9 2 hr. min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) 6/20/41 (b) Allie Selby
(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) Citizen of foreign country _____ (Yes or No)

- If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 3
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

- that I last saw him alive on _____, 19____;

- and that death occurred on the date and hour stated above.

- Immediate cause of death _____ Duration _____

- Due to _____

- Due to _____

- 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?

- While at work? (Specify type of place) (e) Means of injury

23. Signature Eugene M. Brickner (or other)

- Address Columbia Mo Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

