

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED OCT 14 1941MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32717

Registration District No. 816

Primary Registration District No. 4492

Registrar's No. 15

1. PLACE OF DEATH:

- (a) County Scott
 (b) City or town Chaffee
 (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 2 Months
 years, months or days)

3. (a) PRINT
FULL NAMESamuel Lawrence Abernathy3. (b) If veteran,
name war ✓3. (c) Social Security
No. ✓4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,
divorced Married6. (b) Name of husband or wife Virgie Underwood Abernathy 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased March 30 1903
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
38 5 27 _____ hr. _____ min.9. Birthplace Hutesville Mo
(City, town, or county) (State or foreign country)10. Usual occupation Trucker of timber

11. Industry or business

12. Name Sam F Abernathy13. Birthplace Near Hutesville Mo
(City, town, or county) (State or foreign country)14. Maiden name Jubia Fayer15. Birthplace Near Hutesville Mo
(City, town, or county) (State or foreign country)16. (a) Informant Delmer Acup(b) Address 944 N. 4th St Mo17. (a) Burial (b) Date thereof 9-28-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Baker cem Hutesville Mo18. (a) Signature of funeral director Baker Funeral Home(b) Address Hutesville Mo19. (a) 9/28/41 (b) W. D. J. J. J.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Bollinger
 (c) City or town Lawrence Twp Ruxton
 (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 Sept day 27
year 1941 hour 10 minute 45 A.M.21. I hereby certify that I attended the deceased from 9-27-41
1941 to 9-27 1941
that I last saw him alive on 9-27 1941
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis
Dislocation of R Elbow
Subdural hemorrhage
Due to around R. ElbowDue to Accidental
Fall from truck
Other conditions while loading
(Include pregnancy within 3 months of death)
cross tiesMajor findings:
Of operationsOf autopsy 186 W
29

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence 9-27-41
 (c) Where did injury occur? 3 1/2 miles north of Brown
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes while working at work
 while at work? Yes (Specify type of place) (e) Means of injury Fall

Signature W. D. J. J. (M. D. or D. O.)
Address Chaffee Mo Date signed 9-28-41

144
OCT 3 01941

RECEIVED

District Health Office No. 2,

District File Number 1041-1331

Date Filed 10/2/41

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 32717

Registration District No. 816

Primary Registration District No. 4492

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Chaffee
(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 Samuel L. Abernethy
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 37 years
7. Birth date of deceased mar 30, 1903
(Month) (Day) (Year)

8. AGE: Years 38 Months 5 Days 10 If less than one day _____ min.
hr.

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 _____ (State or foreign country)

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) 11/24/41 (b) W. O. Jones
(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 Sept year 1941 hour 8 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

[The page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]