

No. 2
-1-
5.

FILLED NOV 10 1941

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 314

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

1. PLACE OF DEATH:

(a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 425 N. 10th St. W. Main
 (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 PETER ABBOTT

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

4. Sex Male 5. Color or race Col
 6. (a) Single, widowed, married, divorced 03
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>			hr. min.

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

10. Usual occupation R. R. Porter

11. Industry or business M. & T. R. R.

12. Name Peter Abbott

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

14. Maiden name Unknown

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

16. (a) Informant Estella Abbott

(b) Address Sedalia

17. (a) Sedalia (b) Date thereof Oct 29 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia

18. (a) Signature of funeral director F. D. Ferguson

(b) Address Sedalia

19. (a) 10/27/41 (b) Wm. Harry Sreed
(Date received local registrar) (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. 1044
1408 N. 10th (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 (27)
year 1941 hour 6 minute PM

21. I hereby certify that I attended the deceased from 10/15 1941 to 10/27 1941
that I last saw him alive on 10/27 1941
and that death occurred on 10/27 1941 and hour stated above.

Immediate cause of death Stroke
Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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) (e) Means of injury.....

Signature P. W. C. Sawyer (M. D. or other)
Address Sedalia Mo Date signed 10/27/41

17 1944

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-7-41

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.....

F. D. Ferguson

Licensed Embalmer No. *2172*

P. O. Address *Adulua*

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. 35734
Registrar's No. 314

Registration District No. 668

Primary Registration District No. 3032

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

1. PLACE OF DEATH

(a) County Pettis
(b) City or town Sedalia
(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 years, months or days)

3. (a) PRINT FULL NAME Petter Abbott

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

4. Sex M. 5. Color or race B. 6. (a) Single, widowed, married, divorced D.

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 71 Months Days (If less than one day) 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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (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 Oct year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... live on..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Stroke paralysis
Paralysis of legs

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?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-35734