

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19211**
Registrar's No. _____

Registration District No. **19211**

Primary Registration District No. **4492**

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **Oran**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **1**
(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

Matelda Fanne Abbott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **May 23 1863**
(Month) (Day) (Year)

8. AGE: Years **79** Months **8** Days **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housekeeping**

11. Industry or business

12. Name **Jess Phillips**

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

14. Maiden name **Don't know**

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

16. (a) Informant **Mac Edna Francis**

(b) Address **Oran Mo**

17. (a) **Burial** (b) Date thereof **2-21-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oran Mo**

18. (a) Signature of funeral director **J. D. Heiser & Co.**

(b) Address **Oran Mo**

19. (a) **6/1/43** (b) **G. S. Cuckman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Scott**
(c) City or town **Oran**
(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 **Feb** day **19**
year **1943** hour **4** minute **30** A. M.

21. I hereby certify that I attended the deceased from **Nov 1943** to **Feb 19 1943**
that I last saw her alive on **2/19**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Endocarditis**
Duration **1 yr**

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) (b) Means of injury _____

23. Signature **W. A. Clinch** (M. D. or other) _____

Address **Oran Mo** Date signed **2/19/43**

RECEIVED

District Health Office No. 2,

District File Number 648-713

Date Filed 6-2-43

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.