

AUG 10 1943

Registration District No. 38

Primary Registration District No. 3006

State File No.

Registrar's No. 169

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 Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
Specify whether
In this community 16 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Marceline 1
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Abbott

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 14 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 5 28 3 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John L. Abbott
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Frances Whitaker
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant St. Minnie Abbott

(b) Address Marceline, Mo

17. (a) Removal (b) Date thereof 7-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marceline

18. (a) Signature of funeral director Jas. McFarley Klin

(b) Address Marceline, Mo

19. (a) 7-12-1943 (b) Edna H. Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1943 hour 3:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from June 27th
1943, to July 12, 1943
that I last saw her alive on July 12, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death aneurysm of abdominal aorta
Due to _____
Due to _____

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

Major findings: Of operations see above
Of autopsy see above

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 J. Packerman (M. D. or other) M.D.
Address Columbia Cancer Hospital Date signed 7/12/43

10221 (Licensed Embalmer's Statement on Reverse Side) Columbia Mo

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

James M. Langdon

Licensed Embalmer No.

1274

P. O. Address:

Marceline Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 11 1943
State File No. _____
Registrar's No. 169

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Beane
(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 _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Minnie Abbott

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Jan 14 1875
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 10 If less than one day _____ 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 _____
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1943 hour _____ minute _____ M.

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

Immediate cause of death Aneurysm abdominal aorta

Due to Arteriosclerotic in origin

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 J. McNamee (M. D. or other) M.D.
Address Cancer Hospital Columbia Mo. Date signed _____

SUPPLEMENTAL

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

S-24286