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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED OCT 23 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31998

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **8864**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4910 Claxton Ave.  
(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)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4910 Claxton Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Senate Drury Abernathy

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dona Abernathy 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased May 9th 1867  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>5</u>	<u>9</u>	hr. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18th  
year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 10, 1943 to Oct 18, 1944  
that I last saw him alive on Oct 18, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Rheumatic endocarditis

Due to Chol. Rheumatic fever

Due to \_\_\_\_\_

Other conditions Chol. Colitis, Bronchitis, Chol. prostatica  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace \_\_\_\_\_ Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown

{ 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 J. B. Abernathy

(b) Address 4910 Claxton Ave.

17. (a) Burial (b) Date thereof 10-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Long Town Mo.

18. (a) Signature of funeral director Drehmann-Harræ

(b) Address 1905 Union Blvd

19. (a) OCT 19 1944 (b) J. J. Bredick  
(Date received local registrar) (Registrar's signature)

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 Samuel Way (M. D. or other) no

Address 2906 Union Blvd Date signed 10/18/44

(Licensed Embalmer's Statement on Reverse Side)

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

**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..... *Warren A. Carver* .....  
Licensed Embalmer No..... *3534* .....  
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.**