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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 30 1945

Registration District No. 3 8

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8964

Primary Registration District No. 3004

Registrar's No. 48

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 Gatewood Convalescent Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 (Specify whether years, months or days)
In this community 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pettis
(c) City or town Sedalia (If outside city or town limits, write "RURAL")
(d) Street No. 205 E. Morgan St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SYLVIA ABBOTT
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Female | 5. Color or race Negro | 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 1 - 1 - 1864 (Month) (Day) (Year)

8. AGE: Years 81 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Columbia (City, town, or county) Mo. U. (State or foreign country)
10. Usual occupation At home
11. Industry or business —
MOTHER
12. Name Unknown
13. Birthplace — (City, town, or county) — (State or foreign country)
FATHER
14. Maiden name Susan Jones
15. Birthplace Unknown (City, town, or county) — (State or foreign country)
16. (a) Informant Lou Emma Gatewood
(b) Address Columbia Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-29-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Sedalia Mo.
18. (a) Signature of funeral director Ethan O. Parker
(b) Address Columbia Missouri
19. (a) 3-26-45 (Date received local registrar) (b) Edna H. Barbee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25th 30/a
year 1945 hour 10 minute — A.M.

21. I hereby certify that I attended the deceased from 2-21, 1945, to 2-25, 1945, that I last saw h[er] alive on 2-24, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Aortic Regurgitation	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Anemia	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. B. Daugherty (M. D. or other) M.D.
Address 500 Park, Columbia Date signed 3-26-45

1250

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number .....
Date Filed 3-19-45

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 Lucian O. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia [illegible]

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4917

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 48

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

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:
(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

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

3. (a) PRINT FULL NAME Sylvia Abbott
3. (b) If veteran, name war
3. (c) Social Security No.

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

7. Birth date of deceased (Month) Jan (Day) 1 (Year) 1864

8. AGE: Years 81 Months 1 Days Unless less than one day: hr. min.

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

10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 25 year 1945 hour about noon minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to Chronic Nephritis	
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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1/31

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)
While at work (e) Means of injury

23. Signature H. B. Daugherty (M. D. or other) M.D.
Address 500 Park, Columbia Date signed 1/23/45

SUPPLEMENTARY

L. S. Daigle M.D.
500 Park
Columbus, Miss

8964