

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13291

State File No. _____

Registrar's No. _____

FILED MAY 14 1945

Registration District No. 104

Primary Registration District No. 5428

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Holcomb, Mo.
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Un Married "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 divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 1 - 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Bldg

11. Industry or business _____

12. Name Eva Abernathy

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

14. Maiden name Alva Person

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

16. (a) Informant Eva Abernathy

(b) Address Holcomb, Mo.

17. (a) Burial (b) Date thereof 2-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation as outlined in simplified

18. (a) Signature of funeral director Friends

(b) Address Holcomb, Mo.

19. (a) 4-5-45 (b) Mrs. Ernest Vencil, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin
(c) City or town Holcomb, Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3 year 1945 hour _____ minute 0 P. M.

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

Immediate cause of death pericardial effusion Duration _____
failed by clots

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?

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

23. Signature Dr. E. E. E. E. (M. D. or other)
Address _____ Date signed Feb 3/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2

District File Number 545, 648

Date Filed 5-7-45

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.....

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.