

FILED JUN 7 1945
Registration District No. 2-2

Primary Registration District No. 5114

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Rural, Wayne
(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 59 Years (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME Henry Abernathay

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Abernathay 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 27 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 8 12 hr. min.

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

10. Usual occupation

11. Industry or business Farming

12. Name John Abernathay
13. Birthplace North Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Lambert
15. Birthplace No Data
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Abernathay

(b) Address Lownds Mo.

17. (a) Burial (b) Date thereof May 18 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fronabarger Cemetery

18. (a) Signature of funeral director Mathias Service

(b) Address Puxico Missouri

19. (a) May 18 1945 (b) Mrs. Geneva Graham
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. near m^c Lee
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1945 hour 7 30 minute P M.

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

Immediate cause of death Duration

Cerebral Hemorrhage

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) (e) Means of injury 3

23. Signature John Morris (City or town) (State or other)

Address Lownds Mo. Date signed 5/14/45

VED
District Health Officer No. 4
District File Number 645-67
Date Filed 6-6-45

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.....

Lyman Steele

Licensed Embalmer No. *2176*

P. O. Address *Deeter 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.