

FILED JAN 49 1946

Registration District No. **3** Primary Registration District No. **3052**

1. PLACE OF DEATH:

(a) County **Pettis**
(b) City or town **Sedalia**
(If outside city limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
500 North Quincy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **44 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Dollie Ann Abney

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Howard Payne Abney** 6. (c) Age of husband or wife if alive **deceased** years
7. Birth date of deceased **September 27, 1876**
(Month) (Day) (Year)

8. AGE: Years **69** Months **2** Days **25** If less than one day hr. min.

9. Birthplace **Webb, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER
12. Name **Charles W. Mills**
13. Birthplace **Clay County, Iowa**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Morris**
15. Birthplace **Clay County, Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. W. Hoard (dau.)**
(b) Address **500 N. Quincy, Sedalia**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12/24/45**
(Month) (Day) (Year)
(c) Place: burial or cremation **Green Ridge, Mo.**

18. (a) Signature of funeral director **Anne Ewing**
(b) Address **Sedalia, Mo.**
19. (a) **12/24/45** (Date received from registrar) (b) **A. J. Campbell** (Registrar's signature)

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. **500 North Quincy**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **22** 1945
year hour **6** minute **20** M.

21. I hereby certify that I attended the deceased from **1943**
19. to **Dec 22 1945**
that I last saw him alive on **Dec 21 12 am**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia & Influenza** Duration

Due to

Other conditions **Edema of lungs**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy **336**

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)
(e) Means of injury **car**
Signature **J. Brutsche** (M. D. or other)
Address **Sedalia, Mo.** Date signed **12/23/45**

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 1-8-46

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 *Maane Ewing*

Licensed Embalmer No. *3847*

P. O. Address *Sedalia 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.