

No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30637**
Registrar's No. **71**

Registration District No. _____ Primary Registration District No. **3009**

1. PLACE OF DEATH:
(a) County **Cape Girardeau**
(b) City or town **Jackson Mo.**
(c) Name of hospital or institution: **Spradling Nursing Home**
(If not in hospital or institution, write street address) **Spradling Nursing Home**
(d) Length of stay: **1 Week**
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mae Abernathy**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Bert Abernathy** 6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **October, 18, 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 **11** **12** hr. min.

9. Birthplace **Perry Co. Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **House Wife**

11. Industry or business _____
12. Name **Richard Swan**
13. Birthplace **Perry Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Elezbeth Johnson**
15. Birthplace **Perry Co. Mo.**
(City, town, or county) (State or foreign country)
16. (a) Informant **Bert Abernathy**

(b) Address **Longtown Mo.**
17. (a) **Burial** (b) Date thereof **10-3-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **York Chapel Mo.**

18. (a) Signature of funeral director **Springer Sons**
(b) Address **Perry Co. Mo.**
19. (a) **10-3-47** (b) **D. S. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Perry**
(c) City or town **Longtown Mo.**
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** Day **30** Year **1947** hour **10** minute **50 P.**
21. I hereby certify that I attended the deceased from **Jan 1** 19 **47** to **Sept 30** 19 **47**
that I last saw him alive on **Sept 28** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Paralytic disease**
Due to **Paralytic disease**
Due to **Hyper extension**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
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 _____
23. Signature **O. J. Miller** (M. D. or other) _____
Address **Perry Co. Mo.** Date signed **10/1/47**

RECEIVED

District Health Officer No. 4
District File Number 1047-1288
Date Filed 10-8-47

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.....

Frederic W. Bauer, Registered Apprentice No. 510
working under my personal supervision.

Signed Cavanah Young

Licensed Embalmer No. 2138

P. O. Address Perryville 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.