No. 300
10.48

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41720

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 454

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

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hannibal Mo
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levering Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Marion
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hannibal
d. STREET ADDRESS (If rural, give location):

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3. NAME OF DECEASED (Type or Print): a. (First) April b. (Middle) Lee c. (Last) Abbey

4. DATE OF DEATH (Month) Dec (Day) 30 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Colored
7. ~~MARRIED~~, NEVER MARRIED, ~~WIDOWED, DIVORCED (Specify)~~: 1
8. DATE OF BIRTH: 4-4-49
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 8 Days 26; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lincoln Nebraska
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: John Abbey Jr.
13b. MOTHER'S MAIDEN NAME: May Minter
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Zelma Dorsey ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lepto Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 21 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: 3403

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-9, 1949, *to* 12-30, 1949, *that I last saw the deceased alive on* 12-29, 1949, *and that death occurred at* 7.55 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm. A. M. [illegible] M.D.
23b. ADDRESS: Hannibal Mo.
23c. DATE SIGNED: 12-31-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan 1. 1950
24c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery
24d. LOCATION (City, town, or county) (State): Hannibal Mo

DATE REC'D BY LOCAL REG.: 12-31-49
REGISTRAR'S SIGNATURE: D. E. M. Luske [illegible] Deputy
25. FUNERAL DIRECTOR'S SIGNATURE: W. R. Sephus ADDRESS: Hannibal, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JAN 10 1950
MARION CO. HEALTH DEPT.
DATE FILED JAN 12 1950

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~~ .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed W. R. Stephens

Licensed Embalmer No. 3420

P. O. Address Hannibal M

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.