

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1000

STATE FILE NUMBER

30854

Registration District No. 42

Primary Registration District No.

Registrar's No. 1042

1. PLACE OF DEATH a. COUNTY <u>Euchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Joseph</u> TOWN		c. CITY OR TOWN <u>St. Joseph</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>604 N. 11th St.</u>		d. STREET ADDRESS (If outside, give location) <u>604 N. 11th Street</u>	
Length of stay in lb <u>28 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Abbott</u> Last <u>Abbott</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1869</u>
9. AGE (In years last birthday) <u>88</u>		10. FUNDING YEAR Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (City and state or country) <u>Cass County, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Henry Most</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Noon</u>	
14. NAME OF HUSBAND OR WIFE <u>Charles Abbott</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss. Jaunita Abbott</u> Address <u>St. Joseph, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Hemiplegia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I-(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>2:30</u> Month, Day, Year <u>Oct 31-56</u> a.m. <u>P.</u> p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>St. Joseph</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>October 31-56</u> to <u>Sept 25, 1957</u> and last saw her alive on <u>Sept 23-1957</u> Death occurred at <u>2:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Wm W. Fleeman MD</u>	
22b. ADDRESS <u>520 Farmville Dr. St. Joseph, Mo.</u>		22c. DATE SIGNED <u>27/24/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 28, 1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 3, 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.