

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010568
STATE FILE NUMBER

2,3
300
1-57

FILED MAR 23 1959		Registration District No. 310		Primary Registration District No. 3058		Registrar's No. 63	
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles				c. CITY OR TOWN St. Charles		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital				Length of stay in lb 12 Hrs		d. STREET ADDRESS (If outside, give location) 1029 Olive Street	
3. NAME OF DECEASED (Type or print) First MIDDLE Last RUBY R. ABBINGTON				4. DATE OF DEATH Month Day Year March 3, 1959			
5. SEX Male 2		6. COLOR OR RACE Negro		7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		8. DATE OF BIRTH Jan. 28, 1906	
9. AGE (In years last birthday) 53		10. UNDER 1 YEAR Months 1 Days Hours Min.		11. BIRTHPLACE (City and state or country) Jonesboro, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and state or country) Jonesboro, Missouri	
13a. FATHER'S NAME Roy Abbington				13b. MOTHER'S MAIDEN NAME Dora Ricks		14. NAME OF HUSBAND OR WIFE Theodoric Abbington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 491-05-6766		17. INFORMANT Theodoric Abbington, 1029 Olive St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Rupture of cerebral blood vessel DUE TO (c) Generalized arteriosclerosis 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 ☒ NO ☐							
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year				20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred on 6:25 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE J. R. Roberts				22b. ADDRESS 10010 Euclid St. Louis, Mo		22c. DATE SIGNED 3/3/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/6/59		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) St. Charles, Missouri	
24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney				25. DATE RECD. BY LOCAL REG. MARCH 6-59		26. REGISTRAR'S SIGNATURE Marella Wilson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

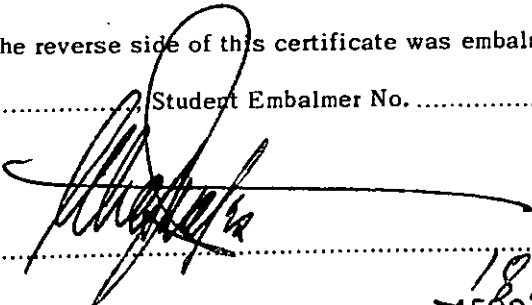
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. ~~4580~~ ¹⁸²⁵

P. O. Address 4107 Finney

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.