Health, Welfare Public Service

300
1-56
10

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022405
STATE FILE NUMBER

FILED JUN 24 1959 Registration District No. 276 Primary Registration District No. 5947 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY: Phelps
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. JAMES Twp. Inside Limits Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Rural ST. JAMES. Length of stay in 1b: 0810

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: Phelps
c. CITY OR TOWN: Rural Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location): Twp. 5947 Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print): First James Middle R. Last Abernathy
4. DATE OF DEATH: Month 6 Day 9 Year 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 11-22-1878
9. AGE (In years last birthday): 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (City and state or country): Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN
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.: 490-01-0766A
17. INFORMANT (Stop-Son) Address: Luther Laswell 6655 Jefferson Berkeley, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic myocarditis about — INTERVAL BETWEEN ONSET AND DEATH: 4 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Bronchopneumonia — 7 days
DUE TO (c): Arteriosclerosis — 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4221
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 WORK ☐ 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 May 27/59 to June 9, 59 and last saw ~~her~~ him alive on May 27, 59
Death occurred at June 9/59 4 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. Hammler, M.D.
22b. ADDRESS: St. James, Mo
22c. DATE SIGNED: June 16/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-13-59
23c. NAME OF CEMETERY OR CREMATORY: City Cemetery
23d. LOCATION (City, town, or county) (State): ST JAMES MO.

24. FUNERAL DIRECTOR ADDRESS: Orol E. Lickleder - St James, Mo.
25. DATE RECD. BY LOCAL REG.: June 17 1959
26. REGISTRAR'S SIGNATURE: Ruth B. Powell

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by .....Me....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Orel E. Lickliel

Licensed Embalmer No. 3 6

P. O. Address St. Jame

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.