

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

60-000167

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>48 Years</b>		c. CITY OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone County Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>706 Clayton</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>CRANSON</b> Last <b>ABRAM</b>			4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-1873</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister &amp; Prof. of Religion</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Minister and Prof. of Religion</b>		11. BIRTHPLACE (City and state or country) <b>Jackson, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert Abram</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Canter</b>		14. NAME OF HUSBAND OR WIFE <b>Lucy Vest</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. R.C. Abram, Columbia, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>GENERALIZED ARTERIO SCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>MANY YRS</b>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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	STATE
21. I attended the deceased from <b>10-1-1957</b> to <b>1-21-1960</b> and last saw her/him alive on <b>1-21-1960</b> Death occurred at <b>9:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John J. Palmer, M.D.</b>				22b. ADDRESS <b>2218th Columbia, Mo.</b>		22c. DATE SIGNED <b>1-23-1960</b>	
23a. BURIAL, CREATION, REMOVAL, (Specify) <b>Burial</b>	23b. DATE <b>1-24-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>Columbia, Missouri.</b>		(State)	
24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Jan 23 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald L Roberts

Licensed Embalmer No. 4222

P. O. Address Columbia

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.