

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-012551

STATE FILE NUMBER

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 276

AMENDED

FILED MAY 1 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Audrain</u> c. CITY OR TOWN <u>Ladsonia</u> d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u>													
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Franklin</u> Last <u>Abbey</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>61</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-96</u>		9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (City and state or country) <u>Rolls County, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13a. FATHER'S NAME <u>Seawess Abbey</u>				13b. MOTHER'S MAIDEN NAME <u>Nancy McElroy</u>				14. NAME OF HUSBAND OR WIFE <u>Virginia Abbey</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>498-07-9540</u>				17. INFORMANT Address <u>Hospital Record Columbia 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>Pulmonary Embolus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Positive Serology</u> <u>Degenerative Spondylasis of Cervical Vertebrae 1-2</u>																	
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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ 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 <u>4-22-61</u> to <u>4-28-61</u> and last saw her/him alive on <u>4-28-61</u> Death occurred at <u>430</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) <u>John H. Legans MD</u>								22b. ADDRESS <u>U. Med Center Columbia</u>				22c. DATE SIGNED <u>4/28/61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>				23b. DATE <u>Apr. 28-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Ladsonia Mo</u>					
24. FUNERAL DIRECTOR <u>Widney & Bimbofey Ladsonia Mo</u>								25. DATE RECD. BY LOCAL REG. <u>April 1961</u>				26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>					

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

MAY 10 1961

MAY 26 1961

OCT 3 1961

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. _____

P. O. Address _____

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.