

AUG 20 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
21768

1. PLACE OF DEATH

County ADAIR
Township.....
City KIRKSVILLE MO (No.....)

Registration District No. 4
Primary Registration District No. 3001

File No. 21768
Registered No. 107
St. Ward)

2. FULL NAME CELINA ABERNATHY

(a) Residence. No. 415 WEST COTTONWOOD St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WIDOWED

6. DATE OF BIRTH (MONTH, DAY AND YEAR) NOV 18 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 7 14

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work HOUSE KEEPER
(b) General nature of industry, business, or establishment in which employed (or employer) SELF
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IOWA

10. NAME OF FATHER CHAS POWELL

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) PA

12. MAIDEN NAME OF MOTHER SARAH BEETS

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) OHIO

14. INFORMANT Geo Cronke (Address) KIRKSVILLE MO

15. FILED 7.16. 19.30 Mrs C. J. Beeper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-3-1930

17. I HEREBY CERTIFY, That I attended deceased from 6-3-1930 to 6-30-1930 that I last saw him alive on 6-30-1930 and that death occurred, on the date stated above, at 12:00 noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
93 1/2
16 1/2

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) myocarditis Ch.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R. B. Stiebler, M. D.
, 19 (Address) Kirksville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL GREEN CASTLE MO DATE OF BURIAL 7-5-1930

20. UNDERTAKER Christe Wilson Kirkville ADDRESS

74-7-16-

11

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Adair Registration District No. 4 File No. _____
 Township _____ Primary Registration District No. 3001 Registered No. 117
 City Kirksville (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 9 7 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 10/10/30 Mrs. O. J. Baker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

8971E-5