

FEB 7 1937

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

Do not use this space.

2186

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. \_\_\_\_\_  
Township Mason Primary Registration District No. 1309 Registered No. 16  
City Harrison (No. 9) Parblehead Hollow St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. Marblehead Hollow 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 Male 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE YEARS 79 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Jabber  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 137  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME Sam Abbey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) Mrs April Abbey

18. BURIAL, CREMATION, OR REMOVAL PLACE Baptist DATE 1-16 1937

19. UNDERTAKER (ADDRESS) 40 E Roberts

20. FILED Jan 12 1937 J. C. Fisher Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 8<sup>th</sup> 1937

22. I HEREBY CERTIFY, That I attended deceased from Dec 13 1936 to Jan 8<sup>th</sup> 1937  
I last saw him alive on Jan 8<sup>th</sup> 1937 Death is said to have occurred on the date stated above, at 10:20 AM

The principal cause of death and related causes of importance were as follows:

Memia  
Intermittent typhoid  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: 121

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. C. Fisher, M. D.  
(Address) Parblehead Mo

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

Do not use this space.

**1. PLACE OF DEATH**

County Marion  
Township  
City Hannibal (No. ....)

Registration District No. 547  
Primary Registration District No. 3029

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME** Abraham Abbey

(a) Residence, No. .... St. .... Ward.  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.

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8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 19 Ernie L. Lelle Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 8 1932

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw him ..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Interstitial nephritis  
Chronic

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....

(Signed) H. B. McMechan, M. D.  
(Address) Hannibal Mo.

SUPPLEMENTAL

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5-2/86