

FILED JUN 7 1944

Primary Registration District No. 1000

Registrar's No. 569

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Saint Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Saint Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hours  
(Specify whether  
In this community Two years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town Saint Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2503 South 14th Street  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

3. (a) PRINT

FULL NAME Mrs. Abbie Louisa Cummins

3. (b) If veteran, name war  
3. (c) Social Security No. 608-14-4678

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband Harold Cummins  
6. (c) Age of husband 40 years if alive  
7. Birth date of deceased December 10, 1904  
(Month) (Day) (Year)

8. AGE: Years 39 Months 5 Days 19 hr. min.

9. Birthplace Humboldt Nebraska  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name James Smith  
13. Birthplace Unknown S. Dakota  
(City, town, or county) (State or foreign country)  
14. Maiden name Edna W. Cummins  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Harold Cummins  
(b) Address 2503 South 14th Street

17. (a) Removal (b) Date thereof June 1, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Falls City, Nebraska

18. (a) Signature of funeral director Mrs. F. R. Sidenfaden  
(b) Address 602 South 10th Street

19. (a) 5-31-44 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th  
year 1944 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from  
Jan 4 1944 to May 29 1944  
that I last saw her alive on May 29 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Toxemia of preg. Duration 5/20/44

Due to: Repl. Ch.

Due to:

Other conditions: Preg. 6 1/2 months - (Include pregnancy within 3 months of death)

Major findings:  
Of operations: 144 R  
Of autopsy:

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)  
(e) Means of injury  
23. Signature: Frank Sidenfaden (M. D. or other)  
Address: 620 Branch Date signed: 5/31/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11  
1  
7

1377

---

---

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Mollie E. Sidenfaden Fox*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, Mo*

**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 this body is not embalmed, fact should be so stated above.**