No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1405

Registration District No. FILED FEB 3 1948 6 — Primary Registration District No. 3026 — Registrar's No. 3

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Independence Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: 999
(c) City or town: Troy 14
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME: MRS. SARAH J. ABEL
3. (b) If veteran, name war: none
3. (c) Social Security No.: none
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife: Eli Abel
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Nov. 27, 1870 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	1	5	hr. min.

9. Birthplace: Unknown, Missouri (City, town, or county) (State or foreign country) 0
10. Usual occupation: housewife
11. Industry or business:
FATHER
12. Name: unknown, Hunt 9
13. Birthplace: unknown (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant: E. B. Abel
(b) Address: 1912 Overton, Independence, Mo.
17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 1/2/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Troy, Kansas
18. (a) Signature of funeral director: Geo. C. Carson
(b) Address: Independence, Mo.
19. (a) 1-5-48 (Date received by local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2 year 1948 hour 3:00 minute P M.
21. I hereby certify that I attended the deceased from 12-30, 1947, to 1-2, 1948 that I last saw h. LR alive on 1-2, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	3 days
Fracture Neck of Left Femur	4 days
~~Due to~~ Senility	
Due to Parkinson Syndrome -	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
Of autopsy: None

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 136
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Harold V Woods M.D. (M. D. or other)
Address: Independence Mo Date signed: Jan 5, 1948.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 William H. Schlanker Registered Apprentice No. 439 working under my personal supervision.

Signed R. A. Lisle

Licensed Embalmer No. 423

P. O. Address Independence, 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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Fet

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sarah J. Abel

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov (Month) 27 (Day) 48 (Year)

8. AGE: Years 77 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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) Accident

(b) Date of occurrence Dec 30 1947

(c) Where did injury occur? 1286 Kansas Indep. Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In the Home (Specify type of place)

While at work? (e) Means of injury Fall

23. Signature Harold V Woods M.D. (M.D. or other)

Address Indep Mo Date signed

SUPPLEMENTARY

S-1405