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0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 19 1950

State File **46155**

BIRTH NO. _____ REG. DIST. NO. **65** PRIMARY REG. DIST. NO. **4113** Registrar's No. **25**

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

1. PLACE OF DEATH a. COUNTY CHARITON		2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission). a. STATE MISSOURI b. COUNTY CHARITON	
b. CITY OR TOWN BRUNSVICK		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BRUNSVICK	
c. LENGTH OF STAY (in this place) 3 YEARS		d. STREET ADDRESS (If rural, give location) 0 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) OPAL	a. (First)	b. (Middle)	c. (Last) ABTEE	4. DATE OF DEATH (Month) (Day) (Year) 5-11-1950
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5. SEX MALE	6. COLOR OR RACE COL	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 11-27-1912	9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY DAY WORK	11. BIRTHPLACE (State or foreign country) DALTON MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME CLEM ABTEE	13b. MOTHER'S MAIDEN NAME HATTIE FRISTO	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR 2	16. SOCIAL SECURITY NO. 701-09-8657	17. INFORMANT'S SIGNATURE OR NAME MRS. JOHN NEAL TRIPLETT	ADDRESS MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal hemorrhage		2 hours
	ANTECEDENT CAUSES DUE TO (b) D. nodosal ulcer DUE TO (c) Obesity 65 lbs overage		7 yrs 60-7 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			5410

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Dec**, 1949, to **May 11, 1950** that I last saw the deceased alive on **May 11, 1950** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Grover C Rice MD (Degree or title)	23b. ADDRESS Brunswick Mo	23c. DATE SIGNED May 11-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5-13-1950	24c. NAME OF CEMETERY OR CREMATORY COLORED CEMETERY TRIPLETT	24d. LOCATION (City, town, or county) (State) MISSOURI
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DATE REC'D BY LOCAL REG. 5-13-50	REGISTRAR'S SIGNATURE Mildred Barnes	56	25. FUNERAL DIRECTOR'S SIGNATURE L. W. ...	ADDRESS ...
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAY 19

District Health Officer No. 8,

District File Number _____

Date Filed 5/19/50

MAX 231950

JUN 6

1950

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.

Signed L. M. Weisler

Signed _____
Student Embalmer

Licensed Embalmer No. 823

P. O. Address Brunswick 91

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.