

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21059

State File No.

FILED AUG 8 - 1955

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 193

1. PLACE OF DEATH a. COUNTY <u>BOONE</u> <u>0105</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BOONE</u> <u>0105</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u>		c. CITY OR TOWN <u>COLUMBIA</u>	
c. LENGTH OF STAY (in this place) <u>12 YES.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1110 PAQUIN ST.</u>		STREET ADDRESS (If rural, give location) <u>1110 PAQUIN</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>L.</u>	c. (Last) <u>ABBOTT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 30, 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <u>0</u>	8. DATE OF BIRTH <u>OCT. 24, 1875</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CARROLL COUNTY, Mo</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>JOHN KNOX ABBOTT</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZA FITTINGS</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS BERT HOPPER</u>	ADDRESS <u>COLUMBIA, Mo.</u>
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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) <u>Cerebral Hemorrhage</u>		<u>3 1/2 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>33IX</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>			

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) (Min.)	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 July 27, 1955, to July 30, 1955, that I last saw the deceased alive on July 30, 1955, and that death occurred at 9:45 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. Hirsong</u>	(Degree or title) <u>D.O.</u>	23b. ADDRESS <u>Columbia Mo</u>	23c. DATE SIGNED <u>7-30-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>AUG 1, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>CLARENCE, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 30 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Hayes</u>	ADDRESS <u>SHELBYNA, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

AUG 9 1954

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..

Student
Signature of Student Embalmer

Signed *Paul E Hayes*

Licensed Embalmer No. *44*

P. O. Address *Shelton,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.