

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013519  
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 55 Primary Registration District No. 30 11 Registrar's No. 24

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CARROLL</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARROLLTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Bogard</u> <u>0170</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME of DAUGHTER.</u>			Length of stay in lb <u>6 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>RFD-2</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA ANN ABEE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 21-1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 6-1880</u>		9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (City and state or country) <u>0</u> <u>CARROLL County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>JAMES Brock</u>			13b. MOTHER'S MAIDEN NAME <u>Missouri Ann POWELL</u>		14. NAME OF HUSBAND OR WIFE <u>Herald Abee deceased.</u>		
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>NO</u>	17. INFORMANT Address <u>MRS Francis Brock CARROLLTON, Mo</u>			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myo-cardial</u> DUE TO (b) <u>Insufficiency</u> DUE TO (c) <u>4222</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Jan 6/58</u> to <u>April 21/58</u> and last saw her alive on <u>April 19/58</u> Death occurred at <u>on the date stated above; and to the best of my knowledge, from the causes stated.</u>							
22a. SIGNATURE (Degree of title) <u>Dr. Hamilton Staten, M.D.</u>				22b. ADDRESS <u>Carrollton Mo.</u>		22c. DATE SIGNED <u>April 22 58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smith Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bogard Mo.</u>		
24. FUNERAL DIRECTOR <u>DICKERSON FUNERAL HOME</u>			ADDRESS <u>Bogard Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4/22/58</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Herbert Palover</u>

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 *R. M. Marshall* .....

Licensed Embalmer No. *4160* .....

P. O. Address *Carrollton* .....

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.