. Health,
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-037542
STATE FILE NUMBER

OCT 30 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10109

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 25 St. Louis City Hosp#1 — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY:

c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 2 69 1200 Monroe — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Adelaide Middle: Last: Abbott

4. DATE OF DEATH: Month: October Day: 21 Year: 1958

5. SEX: F 1

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] 2 **DIVORCED** [ ]

8. DATE OF BIRTH: Nov 10, 1873

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Michigan 1

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Wm Q. Hills

13b. MOTHER'S MAIDEN NAME: Ann Polton

14. NAME OF HUSBAND OR WIFE: William Abbott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: St. Louis City Hospital Records — Address:

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) cerebrovascular accident
DUE TO (c) giant Follicular lymphoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 202.0

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 10/2/58, to 10/21/58 and last saw her/him alive on 10/21/58
Death occurred at 4:45 am/pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Michael S Pozsgay, MD.

22b. ADDRESS: 1515 Lafayette

22c. DATE SIGNED: 10/21/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 10-27-58

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town, or county) (State): St. Louis Co., Missouri

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: OCT 2 2 '58

26. REGISTRAR'S SIGNATURE: J Carl Smith MD
MDB.

(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 ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed Lawrence O. Gerling

Signature of Student Embalmer

Licensed Embalmer No. 4979

P. O. Address St Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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