

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043944

STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6172

300

-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital #2</b>		Length of stay in lb <b>unk</b>	d. STREET ADDRESS (If outside, give location) <b>3001 Woodland</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Roosevelt</b> Middle Last <b>Abercrombie</b>	4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1958</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 6 1924</b>	9. AGE (In years last birthday) <b>34</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wash man</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Faultless Laundry</b>	11. BIRTHPLACE (City and state or country) <b>Waskom Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Matthew Abercrombie</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Douglas</b>	14. NAME OF HUSBAND OR WIFE <b>Annie Lee Abercrombie</b>
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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)	16. SOCIAL SECURITY NO. <b>465-24 4829</b>	17. INFORMANT <b>Annie Ford</b> Address <b>1230 Vine</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Old Cerebral Vascular Accident.</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	<b>3714</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 _____
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21. I attended the deceased from <b>12-14-58</b> to <b>12-25-58</b> Death occurred at <b>12:55 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	21b. last saw her alive on <b>12-25-58</b>	
22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <b>600 East 22nd Street</b>	22c. DATE SIGNED <b>12-26-58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	23d. LOCATION (City, town, or county) (State) <b>Shreveport La.</b>
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24. FUNERAL DIRECTOR <b>E. Sterling Billa</b> ADDRESS <b>1212 Vine St</b>	25. DATE RECD. BY LOCAL REG. <b>12-29-58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmers Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

E. Frank Ellis

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 *E. Sterling Bills* .....

Licensed Embalmer No. *3178* .....

P. O. Address *1212 Pine* .....

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.