

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**68-012959**  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3482**

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 8 1963**

|   |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
|---|------------------|---|-------|--|-----------------|---|---|--|------------------|---|-----------------|----------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                  | b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN  |       | Length of stay in 1b   | c. CITY OR TOWN |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  | b. COUNTY        |   | c. CITY OR TOWN |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |
|   |                  | St. Louis,  |       | 30 minutes   | Dover           |   | Ohio  |  | Tuscarawas       |   | Dover           |                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                  |  |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |                  |   |       | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         |                 | d. STREET ADDRESS (If outside, give location) |   |  |                  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                 |                                  |  |  |  |
| St. Louis City Hosp. D.O.A.   |                  |   |       |  |                 | 1012 Lincoln Avenue                           |   |  |                  |   |                 |                                  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |                  |   | First | Middle   | Last            | 4. DATE OF DEATH                              |   |  | Month            | Day   | Year            |                                  |  |  |  |
| ALMA  |                  |   |       |  | ABBETT          | March   |   |  | 24               | 1963  |                 |                                  |  |  |  |
| 5. SEX  | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |       | 8. DATE OF BIRTH   |                 | 9. AGE (last birthday)                        |   | IF UNDER 1 YEAR  |                  | IF UNDER 24 HR  |                 |                                  |  |  |  |
| Female  | White            |   |       | 9-11-1911  |                 | 51  |   | Months   | Days             | Hours   | Min.            |                                  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  |   |       | 10b. KIND OF BUSINESS OR INDUSTRY  |                 | 11. BIRTHPLACE (City and state or country)    |   | 12. CITIZEN OF WHAT COUNTRY  |                  |   |                 |                                  |  |  |  |
| Housewife   |                  |   |       | Own Home   |                 | St. Louis, Missouri                           |   | U.S.A.   |                  |   |                 |                                  |  |  |  |
| 13a. FATHER'S NAME  |                  |   |       | 13b. MOTHER'S MAIDEN NAME  |                 |   |   | 14. NAME OF HUSBAND OR WIFE  |                  |   |                 |                                  |  |  |  |
| James H. Crump  |                  |   |       | Elizabeth Hoback   |                 |   |   | Ray Abbett   |                  |   |                 |                                  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                  |   |       | 16. SOCIAL SECURITY NO.  |                 | 17. INFORMANT                                 |   | Address  |                  |   |                 |                                  |  |  |  |
| No  |                  |   |       | None   |                 | Mr. Ray Abbett                                |   | 1012 Lincoln Ave.<br>Dover, Ohio   |                  |   |                 |                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:  |                  |   |       |  |                 |   |   |  |                  |   |                 | INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| IMMEDIATE CAUSE (a) <i>Coronary thrombosis with occlusion.</i>  |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| DUE TO (b)  |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| DUE TO (c) <i>4201</i>  |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                  |   |       |  |                 |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.                              |                  |   |                 |                                  |  |  |  |
|   |                  |   |       |  |                 |   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown |                  |   |                 |                                  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                  | 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.  |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| 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  |                  |   |                 |                                  |  |  |  |
|   |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |                  |   |       |  |                 |   |   |  |                  |   |                 |                                  |  |  |  |
| 22a. SIGNATURE (Degree or title)  |                  |   |       |  |                 | 22b. ADDRESS                                  |   |  | 22c. DATE SIGNED |   |                 |                                  |  |  |  |
| <i>Helen L Taylor, Coroner</i>  |                  |   |       |  |                 | <i>1300 Clark Ave.</i>                        |   |  | <i>3-26-63</i>   |   |                 |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY   |                 | 23d. LOCATION (City, town, or county)         |   |  |                  |   |                 |                                  |  |  |  |
| Burial  |                  | March 29, 1963  |       | Bellefontaine Cemetery   |                 | St. Louis, Missouri                           |   |  |                  |   |                 |                                  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |                  |   |       | 25. DATE RECD. BY LOCAL REG.   |                 | 26. REGISTRAR'S SIGNATURE                     |   |  |                  |   |                 |                                  |  |  |  |
| CALVIN F. FEUTZ, 4828 Natural Bridge Bl.  |                  |   |       | MAR 26 1963  |                 | <i>Roan Smith, M.D.</i>                       |   |  |                  |   |                 |                                  |  |  |  |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 John A. Mlinar

Licensed Embalmer No. 4186

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.