

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26888

1. PLACE OF DEATH

County Barry
Towship Cassville Mo.
City Cassville Mo.

Registration District No. 29
Primary Registration District No. 402-1

File No. _____
Registered No. 48
St. _____ Ward _____

2. FULL NAME

Mr. Frank Marion Abolt

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Mary H. Abolt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-15-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 6 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) West Lebanon
(STATE OR COUNTRY) Indiana

10. NAME OF FATHER Jacob Abolt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Vienna Briggs

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky

14. INFORMANT N. S. Abolt
(Address) Shelby St.

15. FILED Sept. 1, 1929 Mrs. N. R. Williams
REGISTRAR Ppt.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 14th 1929

17. I HEREBY CERTIFY That I attended deceased from Aug. 8th 1929, to Aug. 14th 1929 that I last saw him alive on Aug. 13th 1929, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Paralysis and
Cerebral Hemorrhage.

82A
82U
102 (duration) yrs. mos. da.
CONTRIBUTORY Old age
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Truss
(Signed) D. L. Mitchell M. D.
, 19 (Address) Cassville Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Cemetery DATE OF BURIAL Aug. 15th 1929

20. UNDERTAKER Archie's Undertaking ADDRESS Cassville Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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