

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041139

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10842

STATE FILE NUMBER

FILED NOV 7 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY St. Francois   |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |   | Length of stay in lb<br>2 Months   | c. CITY OR TOWN Flat River  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Lutheran Hosp.   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (if outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>FRANKIE M. ABERNATHY  |   |  | 4. DATE OF DEATH<br>Month Day Year<br>Oct. 31, 1963   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>  | 8. DATE OF BIRTH<br>5/29/03   |
| 9. AGE (last birthday)<br>60  |   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Shoe Worker  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Retired   | 11. BIRTHPLACE (City and state or country)<br>Doe Run, Mo.  |
| 12. CITIZEN OF WHAT COUNTRY<br>USA  |   | 13. FATHER'S NAME<br>William Wigger  |   |
| 14. MOTHER'S MAIDEN NAME<br>Unk.  |   | 14. NAME OF HUSBAND OR WIFE<br>Elmer   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |   | 16. SOCIAL SECURITY NO.<br>Unknown   |   |
| 17. INFORMANT<br>Address St. Louis, Mo.<br>Don Simpson, 4124 Beethoven  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>pleurisy and arteriosclerosis</i><br>DUE TO (b) <i>dean</i><br>DUE TO (c) <i>+200</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input 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<br>Hour a.m. p.m.<br>Month, Day, Year   | 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 <i>9-3-63</i> to <i>10-31-63</i> and last saw her alive on <i>10-31-63</i><br>Death occurred at <i>2 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><i>Lester Paushover</i>   |   | 22b. ADDRESS<br><i>5203 Chippewa St. Mo.</i>   | 22c. DATE SIGNED<br><i>11-1-63</i>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  | 23b. DATE<br><i>11/4/63</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Francis  | 23d. LOCATION (City, town, or county)<br>Flat River, Mo.  |
| 24. FUNERAL DIRECTOR<br>McLaughlin, 2301 Lafayette,<br>St. Louis, Mo.   |   | 25. DATE RECD. BY LOCAL REG.<br>NOV 1 1963   | 26. REGISTRAR'S SIGNATURE<br><i>Loed Smith, M.D.</i>  |

USE BLACK INK OR TYPEWRITER RIBBON

CDR. PARASHAK  
5103 CHIPPEWA

8001

810

**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,

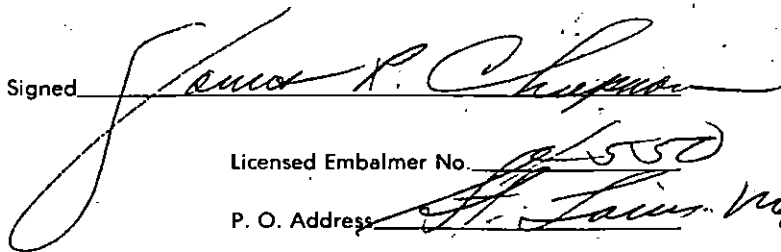
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 5550

P. O. Address H. Laine, Va.

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.