

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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.

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

PLACE OF DEATH
County St Louis
Township Central or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 190 File No. 17830
Primary Registration District No. 6033 Registered No. 124
FULL NAME Robert O. Abel (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)
DATE OF BIRTH August 1st, 1884
(Month) (Day) (Year)

AGE 25 yrs. 10 mos. 26 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Salvage
(b) General nature of industry, business, or establishment in which employed (or employer) Employer

BIRTHPLACE (City or town, State or foreign country) St Louis Mo

PARENTS
NAME OF FATHER Frederick Abel
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dunwood
MAIDEN NAME OF MOTHER Mary Phinip
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis J Abel
(ADDRESS) 4432 Delmar Bl

Filed 6/28/10 101 R. C. Caggus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 6/27 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h - alive on _____, 191____, and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:

Burned under
an electrical Recke
210K (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Rilla Brasiey M. D.
June 29 1910 (Address) Carroll

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence 3851 Page Ave St Louis Mo

PLACE OF BURIAL OR REMOVAL Bellefontaine DATE OF BURIAL 6/29 1910
UNDERTAKER Wagoner Ula ADDRESS 3021 Olive St St Louis Mo

