

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **4183**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4112 Holly Hills
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4112 Holly Hills
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Peter Abel 140

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha Abel 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Feb. 3, 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Brewery worker

11. Industry or business Retired

12. Name Unknown

18. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Abel

(b) Address 4112 Holly Hills

17. (a) Burial (b) Date thereof 5-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cem.

18. (a) Signature of funeral director Southern Trust

(b) Address 6322 S Grand Blvd

19. (a) MAY 10 1940 (b) [Signature]
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th
year 1940 hour _____ minute 72 M.

21. I hereby certify that I attended the deceased from May 22, 1939 to May 8, 1940
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic hemorrhage (apoplexy)
Due to Arteriosclerosis
Due to _____

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address 7702 [Address] Date signed 5/9/40

Duration 1 day
Chronic
Chronic
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Dwyer

10-1

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Vergil L. Berryman

Licensed Embalmer No. *4018*

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 this body is not embalmed, above space should be left blank.