

S. No. 2  
-9.4-41  
-5-17-39  
-PI X2944

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

3791E

State File No. \_\_\_\_\_

FILED DEC 10 1943

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 362

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hr. 45 min  
(Specify whether years, months or days)

In this community One hour 45 minutes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cape Girardeau

(c) City or town Cape Girardeau 016  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DONALD R. GREABLE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov - 25 - 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 0 1 hr. 45 min.

9. Birthplace Cape Girardeau Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Greable

13. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Coates

15. Birthplace Cape Girardeau Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Wm. Greable

(b) Address Cape Girardeau Mo

17. (a) Burial (b) Date thereof Nov. 27-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairmount Cem

18. (a) Signature of funeral director Walther Und. Co.

(b) Address Cape Girardeau Mo.

19. (a) 11-26-43 (b) F. H. Phelps  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25<sup>th</sup>  
year 1943 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from 11-25- 1943 to 11-25- 1943  
that I last saw her alive on Nov 25<sup>th</sup> 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arteriosclerosis

Due to PREMATURITY

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 159

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(f) Means of injury 0

23. Signature A. J. Smith (M., D. or other) MD

Address Cape Girardeau Date signed 11/27/43

1014 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 1243-304

Date Filed 12-8-43

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**