

FILED OCT 18 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **357**

1. PLACE OF DEATH:
 (a) County **Callaway**
 (b) City or town **Fulton**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **State Hospital No 1. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **19 days**
 In this community **same**
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Lincoln**
 (c) City or town **Siles**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2**
 (If rural, give location)
 (e) Citizen of foreign country? **NO.** (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **HERMAN F. PABISH.**

3. (b) If veteran, name war
 3. (c) Social Security No.

4. Sex **M. O.** 5. Color or race **W.**
 6. (a) Single, widowed, married, divorced **M. 1**

6. (b) Name of husband or wife **D. K.**
 6. (c) Age of husband or wife if alive **D. K.** years

7. Birth date of deceased **9. 6. 1864**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 1 3 hr. min.

9. Birthplace **Bloomington, Ill.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **None.**

11. Industry or business

12. Name **D. K.**

13. Birthplace **D. K.**
 (City, town, or county) (State or foreign country)

14. Maiden name **D. K.**

15. Birthplace **D. K.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records.**

(b) Address **Fulton Mo.**

17. (a) **Removal** (b) Date thereof **10-10-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Margus Cem**

18. (a) Signature of funeral director **Joyce M. Mouskoff**

(b) Address **2227 26409 Grandview**

19. (a) **10-10-1947** (b) **Joyce Mouskoff**
 (Date received local returns) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **9**
 year **1947** hour **12** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **10-8-47** 19 to **10-9-47** 19
 that I last saw him alive on **10-9-47** 19
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia.**

Due to
 Due to

Other conditions **Arteriosclerotic heart disease.**
 (Include pregnancy within 5 months of death)

Major findings:
 Of operations
 Of autopsy **9325**

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) (e) Means of injury

Signature **A. P. Price** (M.D. or other)
 Address **Fulton Mo.**

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

4
2

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed

OCT 17 1947

OCT 20 1947

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 Homer Frutz
Licensed Embalmer No. 38482
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, fact should be so stated above.