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1906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34174
Registrar's No. 9064

FILED OCT 30 1948
Registration District No. 318

Primary Registration District No. 1003

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

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:
Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAY 4 1/2 HOURS
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Saline 999
(c) City or town Harrisburg 1/2
(If outside city or town limits, write "RURAL")
(d) Street No. 800 South Main Street, 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHRISTOPHER C. GRABLE
(b) If veteran, name war No
(c) Social Security No. Unknown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month OCTOBER day 16
year 1948 hour 6 p.m. minute 00P. M.
21. I hereby certify that I attended the deceased from October
OCTOBER 13, 1948, to OCTOBER 16, 1948
that I last saw him alive on OCTOBER 16, 1948
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie Grable
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased May 19 1891
(Month) (Day) (Year)

Immediate cause of death
FUNCTIONAL HEART FAILURE 48 HOURS
Duration

8. AGE: Years Months Days If less than one day
57 4 27 hr. _____ min.

Due to ANEMIA AND ARTERIOSCLEROSIS
Due to ANEMIA IS DUE TO ACUTE LEUKEMIA 1 month

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

Other conditions: ARTERIOSCLEROTIC HEART DISEASE
(Include pregnancy within 3 months of death)

10. Usual occupation Mechanic

11. Industry or business Garage

Major findings:
Of operations _____
Of autopsy AS A BOVE
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name John Grable

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

14. Maiden name Rachel Gordon

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

16. (a) Informant Therle Griffith

(b) Address Harrisburg, Missouri

17. (a) Removal (b) Date thereof 10-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisburg, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 19 1948 (b) J. B. Croster
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature Robert H. Ruby, M.D. (M. D. or other) _____
Address Barnes Hospital Date signed _____

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.....

Olmo R. Padwell

Licensed Embalmer No. 4077

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.