

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7385

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (In this place)
St. Louis
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital
e. STREET ADDRESS (If rural, give location)
18 4252 Swan Ave #149

3. NAME OF DECEASED (Type or Print)
a. (First) Albert b. (Middle) J. c. (Last) Gable Sr
4. DATE OF DEATH (Month) (Day) (Year)
8-9-1954

5. SEX M 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 1883 71
9. AGE (In years last birthday) Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work when during most of working life, even if retired) Night Watchman
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME William Gable
13b. MOTHER'S MAIDEN NAME Elizabeth Withouse
14. NAME OF HUSBAND OR WIFE Rose Gable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 491-18-8887
17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Rose Gable - 4252 Swan Ave

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
DUE TO (b) Fracture Hip
DUE TO (c) Carcinoma of the Prostate (Pathological)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____
19b. MAJOR FINDINGS OF OPERATION _____
20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? 177XF

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 8. 10. 54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-11-1954
24c. NAME OF CEMETERY OR CREMATORY Calvar. Cemeter.
24d. LOCATION (City, town, or county) (State) St. Louis Mo

DATE REC'D BY LOCAL REG. AUG 10 1954
REGISTRAR'S SIGNATURE Carl Smith
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edw Koch & Son - 2516 S. 14th

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

[Handwritten signatures and scribbles]

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Bill C. Bureau*

Licensed Embalmer No. *476*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.