

Health,
Welfare
Public
Service

300
1-56

decease, coroner, etc., must use any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FRIED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18675
STATE FILE NUMBER
5368
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL			Length of stay in lb 2 2/3		d. STREET ADDRESS (If outside, give location) 4336 Gertrude Ave. Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARIE Middle SARAH Last GABELMANN			4. DATE OF DEATH Month JUNE Day 7 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30 1898	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gett Lieb Allicheh			14. MOTHER'S MAIDEN NAME Sarah ?????		
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. None		INFORMANT Address William J. Gabelmann 4336 Gertrude Av	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aplastic Anemia					INTERVAL BETWEEN ONSET AND DEATH 7 Mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myelofibrosis					
DUE TO (c) 292.4					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from MAY 20, 1957 to JUNE 7, 1957 and last saw her/him alive on JUNE 7, 1957 Death occurred at 2:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) C. D. Amelias, M.D.			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 6/8/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-10-1957	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetary		23d. LOCATION (City, town, or county) (State) 7901 Gravois Ave
24. FUNERAL DIRECTOR Fiegender Bros		ADDRESS 6409 Gravois Ave.		25. DATE RECD. BY LOCAL REG. JUN 10 '57	26. REGISTRAR'S SIGNATURE Carl Smith MD mjs

(Licensed Embalmer's Statement on Reverse Side)

ISSUED

DATE

ST. LOUIS, MISSOURI

STATE OF MISSOURI

JUNE 1, 1951

CHARLES

BARBARA

MARIE

SS

DEPT. OF HEALTH

White

Female

U.S.A.

Missouri

Residence

Death 1951

Official Record

VA of Missouri

and

to

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 *Van M. Superior*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.

(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.

NOT RECORDED

MISSOURI DEPARTMENT OF HEALTH

6-10-1951

REMOVED

MISSOURI DEPARTMENT OF HEALTH