Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003683
STATE FILE NUMBER

FEB 11 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 268

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY OR TOWN CLAYTON — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. L. CO. HOSP. — Length of stay in 1b: 1 Day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY ST. LOUIS
c. CITY OR TOWN OVERLAND — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 10310 DRIVER — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Melvin — Middle — Last Abel
4. DATE OF DEATH: Month 1 Day 28 Year 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-29-1910
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt.
10b. KIND OF BUSINESS OR INDUSTRY: Sheet Metal
11. BIRTHPLACE (City and state or country): St. Louis
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: Abel
13b. MOTHER'S MAIDEN NAME: Duffy
14. NAME OF HUSBAND OR WIFE: Eugenia Abel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-01-3612
17. INFORMANT: Eugenia Abel, Address: Overland, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive & Arteriosclerotic Disease.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis 331X
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1-27-59, to 1-28-59 and last saw her/him alive on 1-28-59
Death occurred at 2:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. B. Kelley (Degree or title) M.D.
22b. ADDRESS: 601 So. Brentwood
22c. DATE SIGNED:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-30-1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Ortmann F. Home — ADDRESS: 9222 Lackland
25. DATE RECD. BY LOCAL REG.: 1-28-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 3478

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.