

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010370

AMENDED FILED APR 14 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3186 STATE FILE NUMBER

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in lb 13 days | | c. CITY OR TOWN St. Louis, | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospitals, Inc. | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 4217 Holly St., | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Phillip Last Abel | | | 4. DATE OF DEATH Month April Day 3, Year 1961. | | | 5. SEX Male | | 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 Dec. 21, 1878 | | 9. AGE (last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paperhanger | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (City and state or country) Orange, Texas | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME Walter Abel | | | | 13b. MOTHER'S MAIDEN NAME Unknown Lord | | | | 14. NAME OF HUSBAND OR WIFE Aline | | | |
| 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. | | 17. INFORMANT Address Aline Abel 4217 Holly Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) with MYOCARDIAL FAILURE | | | | | | 2 Wks | | |
| | | | DUE TO (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | 10 Yrs | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OSTRITIS DEFORMANS - GENERALIZED | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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.) 420.0 | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 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 1950 to April 3, 1961 and last saw him alive on April 3, 1961 Death occurred at 5:15 P.M., m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Johna Currier, M.D. | | | | | | 22b. ADDRESS 1755 South Grand Blvd., | | | 22c. DATE SIGNED 4-4-61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4/6/61 | | 23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEMETARY | | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MISSOURI | | | | |
| 24. FUNERAL DIRECTOR Stroot & Carroll Funeral Home | | | | ADDRESS 4600 Natural Bridge | | 25. DATE RECD. BY LOCAL REG. APR 5 1961 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | | |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

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 W. W. Krieter

Licensed Embalmer No. 4865

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.