

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042150

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10985** STATE FILE NUMBER

FILED DEC 12 1961

1. PLACE OF DEATH
 a. COUNTY MISSOURI
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS, Length of stay in 1b
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4217 HOLLY AVE Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4217 HOLLY AVE Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
 ALINE G. ABEL NOV, 24, 1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH NOV. 2, 1885 9. AGE (last birthday) 76 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) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) NEW ORLEANS LA, U.S.A. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME UNKNOWN 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE THOMAS P. ABEL

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 17. INFORMANT HAROLD ABEL 8456 AEDER Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) *Strangulation due to hanging, performed when deceased hanged self in basement of home on Nov. 24, 1961.*
 DUE TO (b) *Berkeley MO*
 DUE TO (c) *Suicide*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) *974x* PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) *See above*

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year *11-24-61*

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.) *Home* 20f. CITY, TOWN, OR LOCATION COUNTY STATE *St Louis, Mo*

21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *[Signature]* 22b. ADDRESS *1300 Clair* 22c. DATE SIGNED *11-27-61*

23. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 11/28/61 23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEMETERY 23d. LOCATION (City, town, or county) STATE ST LOUIS COUNTY MO.

24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE 25. DATE RECD. BY LOCAL REG. NOV 27 1961 26. REGISTRAR'S SIGNATURE *Boyd Smith. M.D.*

DOCUMENT

MEDICAL CERTIFICATION

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 M W Ruster

Licensed Embalmer No. 4865
P. O. Address St Louis Mo

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.