

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33891**
Registrar's No. **8589**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **De Paul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Hours**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **INFANT ABERLE.**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 16, 1940.**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **2 hr.** min.

9. Birthplace **St. Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER FATHER { 12. Name **Leo L. Aberle.**
13. Birthplace **Belleville, Illinois.**
(City, town, or county) (State or foreign country)
14. Maiden name **Opal Iona Tucker.**
15. Birthplace **Montgomery Co. Missouri.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Leo L. Aberle.**
(b) Address **2143 Oak Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-18-1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **Lake Charles Cemetery.**

18. (a) Signature of funeral director **Geo. L. Pleitsch Inc.**

(b) Address **5966-68 Easton Ave**

19. (a) **OCT 18 1940** (b) **J. P. Bulech**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **2143 Oak Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **16th.**
year **1940** hour **8** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 16**, 19**40** to **Oct. 16**, 19**40**,
that I last saw her alive on **Oct. 16**, 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Thrombosis Inter cerebral Cerebral Edema** Duration **1-2 hrs**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **Thrombosis Inter cerebral Cerebral Edema**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature **J. P. Bulech** (M. D. or other) **MD**
Address **5899 Delmar** Date signed **10/17/40**

Dr. L. F. Hayden.
5899 Delmar Blvd.
Cabany 7201

not embalmed

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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 this body is not embalmed, above space should be left blank.