

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED DEC 7 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39095

Do not use this space.

1. PLACE OF DEATH

(a) County WEBSTERRegistration District No. 373

(b) Township

Primary Registration District No. 4544Registered No. 60(c) City NIANOA

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Christene Jane Cabel-(a) Residence, No. _____ St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fm. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) may 31 19447. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 4 - 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____ 9. Industry or business in which work was done, as saw mill, bank, etc. _____ 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Joberon mo.FATHER 13. NAME Jos. Cabel.14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kens.MOTHER 15. MAIDEN NAME Josephine Weiler16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kens.17. INFORMANT (ADDRESS) Fry Cabel18. BURIAL, CREMATION, OR REMOVAL PLACE Joberon DATE Oct 7 194419. FUNERAL DIRECTOR (NAME) (ADDRESS) Palmer General Home20. FILED Nov 15 1944 Charlotte Bruce Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5 194422. I HEREBY CERTIFY, That I attended deceased from Oct 4 1944 to Oct 5 1944I last saw her alive on Oct 5 1944 Death is said to have occurred on the date stated above, at 5 a.m.

The principal cause of death and related causes of importance were as follows:

IntestinalObstruction

Date of onset

Other contributory causes of importance: 122 lb

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. J. Behrnick, M. D.(Address) Wongard mo

RECEIVED

District Health Officer No. 6,

District File Number 1244-1286

Date Filed DEC 5 1944

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.

not embalmed

Signed

R. A. Rubner

Licensed Embalmer No.

1161

P. O. Address

L. H. H. H.

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.