No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21542

FILED JUL 19 1945

Registration District No. 349 Primary Registration District No. 6223 Registrar's No. 44

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town El Dorado Springs, Mo. Virgil Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 17 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 108

(a) State Missouri (b) County Vernon

(c) City or town El Dorado Springs (Rural) (If outside city or town limits, write "RURAL")

(d) Street No. Virgil Township (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Otto Wilhelm Abele

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M O

5. Color or race W

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 28 (Day) 1885 (Year)

8. AGE: Years 59 Months 10 Days 23 If less than one day hr. min.

9. Birthplace Sternheim (City, town, or county) Germany (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Carl L. Abele
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Caroline Yager
15. Birthplace Sternheim (City, town, or county) Germany (State or foreign country)

16. (a) Informant Vernon O. Abele

(b) Address El Dorado Springs, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Blakely Cemetery

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Mo

19. (a) 6/13-45 (Date received local registrar) (b) G T Pyzel (Registrar's signature)

1379

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1945 hour 4 minute 5 A.M.

21. I hereby certify that I attended the deceased from May 10, 1945, to May 21, 1945 that I last saw him alive on May, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	Dont Know,
Due to Dont Know.	
Due to	
Other conditions Br. Pneumonia (Include pregnancy within 3 months of death)	10 days

Major findings: Of operations none 93

Of autopsy none

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 W S Love (M. D. or other) MD

Address Nevada MO Date signed 5/24/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 6-45-705
Date Filed 7-13-45

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

Signed J B Ferry

Licensed Embalmer No. 1760

P. O. Address Nevada 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 this body is not embalmed, fact should be so stated above.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 35-9 Primary Registration District No. 6223 Registrar's No. 448

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural El Dorado Springs (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Otto W. Ahle

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife .....

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

7. Birth date of deceased June 28 (Month) (Day) (Year)

8. AGE: Years 59 Months ..... Days ..... If less than one day ..... hr. ..... min.

9. Birthplace Germany (City, town, or county) (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 6-13-45 (Date received local registrar) (b) G. T. Joyce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... Day ..... year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw h..... alive on ..... 19..... ; and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Due to .....

Due to .....

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

Major findings:
Of operations .....

Of autopsy .....

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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

21542