

FILED JUN 7 1948

Registrar's No. 14

Registration District No. 2

Primary Registration District No. 3071

1. PLACE OF DEATH:

(a) County Saline  
 (b) City or town State  
 (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 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline  
 (c) City or town State (If outside city or town limits, write "RURAL")  
 (d) Street No. 575 West Park (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country: 1

3. (a) PRINT FULL NAME Mathias Henry Bable

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1948 hour 5 minute 4 M.

3. (b) If veteran, name war ✓ 3. (c) Social Security No. Oldag

21. I hereby certify that I attended the deceased from May 14 to May 20, 1948, that I last saw him alive on May 20, 1948, and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white (a) Single, widowed, married, divorced single

Immediate cause of death: Terminal Pneumonia Duration 3 hrs

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

Due to: Carcinoma Prostate

7. Birth date of deceased: April 2 - 1886 (Month) (Day) (Year)

8. AGE: Years 82 Months 19 Days 19 min.

Due to: Other conditions: type 2 fell injuring left 20 days

9. Birthplace: New Frankfurt Saline Co Mo (City, town, or county) (State or foreign country)

Other conditions: type 2 (Specify pregnancy within 3 months of death)

10. Usual occupation: Retired Grocer

11. Industry or business

Major findings: None - 510

12. Name: Michael Bable

Of operations: None - 510

13. Birthplace: Switzerland (City, town, or county) (State or foreign country)

Of autopsy: None

14. Maiden name: Barbara Reider

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

16. (a) Informant: Mrs. Rose Bable

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

(b) Address: State Mo

(a) Accident, suicide, or homicide (specify): None

17. (a) Date thereof: May 23 (Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence: 5/8

(c) Place: burial or cremation: State City

(c) Where did injury occur? (City or town) (County) (State)

18. (a) Signature of funeral director: State Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work (Specify type of place) (e) Means of injury: None

19. (a) 5-27-48 (b) Mo. Seal E. Metz (Date received local registrar) (Registrar's signature)

23. Signature: J. P. Leatherwood (M. D. or P. D.)

Address: State Mo Date signed: 5/27/48

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-4-48.....

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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No. 3143

P. O. Address State, Md.

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.