

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **32801**

FILED SEP 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8144**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>ST LOUIS</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>2139 1/2 5400 Arsenal Street</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mabel</b>	a. (First)	b. (Middle)	c. (Last) <b>Abbott</b>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>August 20, 1953</b>
--	------------	-------------	-------------------------	--

<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Widow?</b>	<b>8. DATE OF BIRTH</b> <b>2-15-88</b>	<b>9. AGE</b> (In years last birthday) <b>65</b>	<b>IF UNDER 1 YEAR</b> Months	<b>IF UNDER 2 HRS.</b> Days	<b>IF UNDER 2 HRS.</b> Hours	<b>IF UNDER 2 HRS.</b> Min.
--------------------------------	---	--	---	--	----------------------------------	--------------------------------	---------------------------------	--------------------------------

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>ST LOUIS MO</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
--	--	---	---

<b>13a. FATHER'S NAME</b> <b>Sam Murphy</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Ann Burke</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>?</b>
--	---	--

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>EUGENE ABBOTT - OVERLAND MO</b>	<b>ADDRESS</b>
--	---	--	----------------

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pulmonary Tuberculosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 yrs.</b>
	<b>ANTECEDENT CAUSES</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	<b>DUE TO (b)</b>		
	<b>DUE TO (c)</b>		
	<b>II. OTHER SIGNIFICANT CONDITIONS</b> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------------	---	--

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>002X</b>
---	---	---

<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
---	--	-----------------------------------

**22. I hereby certify that I attended the deceased from 11-16-, 19 50, to 8-20, 19 53 that I last saw the deceased alive on 8-20, 1953, and that death occurred at 11:30pm from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>Philip O. Dale M.D.</i>	(Degree or title)	<b>23b. ADDRESS</b> <b>5400 Arsenal Street</b>	<b>23c. DATE SIGNED</b> <b>8-20-53</b>
---	-------------------	---	---

<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>24b. DATE</b> <b>8-22-53</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>MEMORIAL PARK</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>ST LOUIS MO</b>
---	------------------------------------	---	--

<b>DATE REC'D BY LOCAL REG.</b> <b>AUG 21 1953</b>	<b>REGISTRAR'S SIGNATURE</b> <i>J. Earl Smith, M.D.</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>ORTMANN Home</i>	<b>ADDRESS</b> <b>OVERLAND MO</b>
---	--	--	--------------------------------------

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

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 *Al C Ostmann*.....  
Licensed Embalmer No. *3478*.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.