

FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39379

STATE FILE NUMBER

318

1003

9565

Registration District No. _____ Primary Registration District No. _____ Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission). STATE COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN			Inside Limits #s <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last ERNST P FABEL			4. DATE OF DEATH Month Day Year OCT 19 1956		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	
Male	White		May 11 1886	70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Clerk		Office		Waterloo Ill	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Fred Fabel			Catherine Rodenheiser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		498-09-3554		Edna Fabel 8734 Windom	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					6 months
DUE TO (b) <i>Chronic Asthma</i>					
DUE TO (c) <i>Cause of the Lunges</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Aug 1956</i> to <i>Oct 18-1956</i> and last saw her/him alive on <i>Oct 18-1956</i> Death occurred at <i>4 PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
<i>Walter B. Bowell M.D.</i>			<i>4660 Maryland</i>		<i>10/19/56</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial	10/22/56	Calvary Cemetery		St Louis Mo	
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE
Ortmann F Home 9222 Lackland			Mo OCT 20 1956		<i>Paul Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED BY THE REGISTRAR

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *R. C. Ortman*.....

Licensed Embalmer No. 3

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.