

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005025

STATE FILE NUMBER

FILED FEB 17 1958

Registration District No. 115-216 Primary Registration District No. 3028 Registrar's No. 72

300 0
-57

1. PLACE OF DEATH a. COUNTY Franklin			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gasconade		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Stonyhill Mo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp		Length of stay in lb 3 Hrs	d. STREET ADDRESS (If outside, give location) 1/8 Mi East of S. Hill		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OLIVER Middle HERBERT Last GABLER			4. DATE OF DEATH Month 2 Day 13 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1928	9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months - Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle trucker	10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (City and state or country) Stonyhill, Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME L. Michael Gabler		13b. MOTHER'S MAIDEN NAME Dewia Hill		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 495-28-4181	17. INFORMANT Address Mrs. Dewia Gabler, Stonyhill, Mo		
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>Severe carbon monoxide poisoning with compound skull fracture.</i> DUE TO (b) <i>Skull fracture.</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT <input checked="" 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.) <i>This occurred in a highway truck accident</i>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <i>2/13/58</i>					
20d. INJURY OCCURRED WHILE AT <input checked="" 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.) <i>Highway 66</i>	20f. CITY, TOWN, OR LOCATION <i>West of Pacific Mo</i> COUNTY <i>Franklin</i> STATE <i>Mo</i>			
21. I attended the deceased from <i>2/12/58</i> to <i>2/13/58</i> and last saw her/him alive on <i>2/13/58</i> Death occurred at <i>1:10 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS <i>Washington Mo</i>		22c. DATE SIGNED <i>2/14/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial	2-16-1958	St. James E&R Cem.		Stonyhill Mo	
24. FUNERAL DIRECTOR <i>Lawrence Blumberg Berger Mo</i>		25. DATE RECD. BY LOCAL REG. <i>2/14/58</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 30 1958

FEB 19 1958

MAR 12 1958

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 *John S. Dennehy*
Licensed Embalmer No. *4199*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.