

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010652

STATE FILE NUMBER

2054

FILED MAR 23 1959

Registration District No.

Primary Registration District No.

Registration No.

09  
300  
1-57

20

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lemay <i>4850</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hosp		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 2230 Pecan Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Rochelle Mary Abel			4. DATE OF DEATH Month Day Year Feb. 26, 1959
5. SEX Female	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 2/25/59
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 1 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Walter Abel	13b. MOTHER'S MAIDEN NAME Dorothy Chancellor
14. NAME OF HUSBAND OR WIFE		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. none
17. INFORMANT Walter Abel		Address 2230 Pecan Dr. Lemay, 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>PREMATURITY (BIRTH WT. 2 lb 9 oz)</i>			INTERVAL BETWEEN ONSET AND DEATH <i>17 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>77 1/2%</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>Feb 25 59</i> to _____ and last saw her alive on <i>Feb 25 2 PM</i> . Death occurred at <i>20:</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Sharon T. Y. Shuler, M.D.</i>		(Degree or title)	22b. ADDRESS <i>1695 S. Brentwood St. St. Louis, Mo.</i>
22c. DATE SIGNED <i>Feb 26 59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <i>2/27/59</i>	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR E. J. Schnur		ADDRESS 3125 Lafayette Ave.	25. DATE RECD. BY LOCAL REG. FEB 26 '59
		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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.

*Mr Embalmer*

Student .....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No.....

P. O. Address.....

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.