

# UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 8 1959

59-040687

STATE FILE NUMBER

Registration District No. 163 Primary Registration District No. 5596 Registrar's No. 87

|                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                   |                                     |                                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JEFFERSON</b>                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>JEFF</b> |                                     |                                                                                                                                                                      |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>DeSoto (VALLE)</b>                                                                                                                                                                                                                                       |                                                                                                           | Length of stay in 1b<br><b>YAS.</b>                                                                                                                         |                                                                                              | c. CITY OR TOWN <b>DeSoto RURAL</b>                                                                                               |                                     | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                 |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>10 MI W. OF DeSoto OFF HYH, 1 1/2 MI.</b>                                                                                                                                                                                                   |                                                                                                           | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                        |                                                                                              | d. STREET ADDRESS (If outside, give location)<br><b>10 MI W. OF DeSoto OFF HYH, 1 1/2 MI.</b>                                     |                                     | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>ALBERTO GONZALES ABREU</b>                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                                              | 4. DATE OF DEATH<br>Month Day Year<br><b>Nov 25 1959</b>                                                                          |                                     |                                                                                                                                                                      |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                               | 6. COLOR OR RACE<br><b>N</b>                                                                              | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                                              | 8. DATE OF BIRTH<br><b>Nov 10 1878</b>                                                                                            | 9. AGE (last birthday)<br><b>81</b> | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.                                                                                                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RET. CUBAN COUNSEL</b>                                                                                                                                                                                                         |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>PIP. SERVICE</b>                                                                                                    |                                                                                              | 11. BIRTHPLACE (City and state or country)<br><b>CEIN FUEGAS, CUBA</b>                                                            |                                     | 12. CITIZEN OF WHAT COUNTRY<br><b>CUBA</b>                                                                                                                           |  |
| 13a. FATHER'S NAME<br><b>LEOPOLD G. ABREU</b>                                                                                                                                                                                                                                                                                    |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><b>DELORES SANCHEZ</b>                                                                                                         |                                                                                              | 14. NAME OF HUSBAND OR WIFE<br><b>ELSIE ABREU</b>                                                                                 |                                     |                                                                                                                                                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                         |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                                      |                                                                                              | 17. INFORMANT<br>Address<br><b>ELSIE ABREU, DeSoto STAR ROUTE</b>                                                                 |                                     |                                                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Myocarditis</b><br>DUE TO (c) <b>Hypertension</b> |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>                                                                                                                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                   |                                     | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour a.m. p.m.<br>Month, Day, Year                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                   |                                     |                                                                                                                                                                      |  |
| 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 <b>June, 1958</b> to <b>Nov. 25, 1959</b> and last saw him alive on <b>Nov. 24, 1959</b><br>Death occurred at <b>November 25, 1959 12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                            |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                   |                                     |                                                                                                                                                                      |  |
| 22a. SIGNATURE<br>(Degree or title)<br><b>R.E. Fure</b>                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                                              | 22b. ADDRESS<br><b>105 Easton DeSoto Ma</b>                                                                                       |                                     | 22c. DATE SIGNED<br><b>11-29-59</b>                                                                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>DEC 5, 1959</b>                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAVANA VIA (MIAMI)</b>                                                                                             |                                                                                              | 23d. LOCATION (City, town, or county)<br><b>HAVANA CUBA</b>                                                                       |                                     |                                                                                                                                                                      |  |
| 24. FUNERAL DIRECTOR<br><b>PIETRICH F. HOME</b>                                                                                                                                                                                                                                                                                  |                                                                                                           | ADDRESS<br><b>DeSoto Mo</b>                                                                                                                                 |                                                                                              | 25. DATE RECD. BY LOCAL REG.<br><b>Dec. 5-1959</b>                                                                                |                                     | 26. REGISTRAR'S SIGNATURE<br><b>Marie Harris</b>                                                                                                                     |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Donnell Fred Dietrich, Student Embalmer No. 588

working under my personal supervision.

Student Donnell Fred Dietrich  
Signature of Student Embalmer

Signed Donnell B. Dietrich

Licensed Embalmer No. 4104

P. O. Address Depto 7

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.