

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

-60-038155

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 280 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in lb <u>5 Days</u>		c. CITY OR TOWN <u>Adrian</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Grand River Township</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Pete</u> Last <u>Gabriel</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Monitaeu Co. Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Earl C. Gabriel</u>			13b. MOTHER'S MAIDEN NAME <u>Jennie Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie Gabriel</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>490-30-4261</u>	17. INFORMANT Address <u>Mrs. Lillie Gabriel, Adrian, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Lobes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>Metastatic C. of Lung</u> DUE TO (c) <u>Primary C. of Penis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? 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 Hour <u> </u> a.m. <u> </u> p.m.		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 <u>1958</u> to <u>Nov 5 1960</u> and last saw <u>him</u> alive on <u>Nov 5 1960</u> Death occurred at <u>12:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>100</u>				22b. ADDRESS <u>Clinton Mo.</u>		22c. DATE SIGNED <u>Nov 6 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-5-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Adrian, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Six Funeral Service, Adrian, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 9 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Biggers</u>		

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

0961 S T AON

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed _____ *[Signature]*

Licensed Embalmer No. 3650

P. O. Address Adrian, Mo.

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