

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

318

1003

12479

-60-047466

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5169 Goethe Ave.</b>		d. STREET ADDRESS (If outside, give location) <b>5169 Goethe Ave.</b>	

3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>E.</b> Last <b>FABEL</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-1906</b>	9. AGE (last birthday) <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Piedmont, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>George M. Diggs</b>		13b. MOTHER'S MAIDEN NAME <b>Maude Lipe</b>	
14. NAME OF HUSBAND OR WIFE <b>Adolph K. Fabel</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Adolph K. Fabel</b>		Address <b>5169 Goethe Ave.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>157X</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ a.m. _____ 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 **Sept. 9, 1953** to **Dec. 26, 1960** and last saw her/him alive on **Dec. 26, 1960**  
Death occurred at **5:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Grace E. Bergner, M.D.</b>	22b. ADDRESS <b>114 N. Taylor Ave. (8)</b>	22c. DATE SIGNED <b>12-27-60</b>
-------------------------------------------------------------------	-----------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 29, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 27 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
------------------------------------------------------------------------	----------------------------------------------------	------------------------------------------------------

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Steward

Licensed Embalmer No. 400

P. O. Address St. Louis

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.