

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12155

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 111

112
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1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Henry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. LENGTH OF STAY (in this place) 9yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Moores Rest. Home		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton	
		d. STREET ADDRESS (If rural, give location) 2 0	

3. NAME OF DECEASED (Type or Print) Albert			a. (First)			b. (Middle) *			c. (Last) Gabriel			4. DATE OF DEATH (Month) (Day) (Year) May 3 1949		
5. SEX male			6. COLOR OR RACE white			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single			8. DATE OF BIRTH April 21 1861			9. AGE (In years last birthday) 85		
												10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		
												11. BIRTHPLACE (State or foreign country) Ohio /		
												12. CITIZEN OF WHAT COUNTRY? U S A		

13a. FATHER'S NAME Joseph Gabriel			13b. MOTHER'S MAIDEN NAME Elizabeth Micheal			14. NAME OF HUSBAND OR WIFE None		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None None		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Moore		ADDRESS Clinton Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Meningitis					
		ANTECEDENT CAUSES DUE TO (b) Arterio-sclerosis					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4500	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from 4-15-1949, to 5-3, 1949, that I last saw the deceased alive on 4-29, 1949, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE Ed. P. Proctor M.D.		23b. ADDRESS Clinton Mo		23c. DATE SIGNED 5/4/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 5 1949		24c. NAME OF CEMETERY OR CREMATORY Deepwater		24d. LOCATION (City, town, or county) (State) Deepwater MO	
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DATE REC'D BY LOCAL REG. 5-4-49		REGISTRAR'S SIGNATURE Florence Adarvo		25. FUNERAL DIRECTOR'S SIGNATURE Fred Welberison		ADDRESS Clinton MO	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7

District File Number 4-49-51

Date Filed 5-9-49

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

None

Student Embalmer No.

None

working under my personal supervision.

Signed

None

Student Embalmer

Signed

Francis Lee Schaefer

Licensed Embalmer No.

4513

P. O. Address

Clinton Md

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 this body is not embalmed, fact should be so stated above.