

Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **3 months** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County _____
(c) City or town **Coffeyville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mrs. Paula H. Weible** **140**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Harry C. Weible** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 29, 1866**
(Month) (Day) (Year)

8. AGE: Years **73** Months **8** Days **15** If less than one day hr. _____ min.

9. Birthplace **New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

12. Name **John Hazard**

18. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Helen Latham**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fern Hoffman**

(b) Address **708 W. 47th**

17. (a) **Burial** (b) Date thereof **June 15, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Coffeyville, Kansas**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **104 W. 42nd St., K.C., Mo.**

19. (a) **June 14, 1940** (b) **M. M. Grove**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **14**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **May 11,** 19**39** to **June 14,** 19**40**;
that I last saw her alive on **June 14,** 19**40**
and that death occurred on the day and hour stated above.

Immediate cause of death **Aspiration Pneumonia** **2 wks.**
& Metastatic Lung Abscess.

Due to **Chronic Adipitis**
terminal pneumonia 10 days

Due to _____

Other conditions **Seizure 10/10**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **Lung Abscess**
of both lungs

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature **Paul H. Johnson** M. D. or other _____
Address **Kansas City** Date signed **6/14/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 24 1954

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 _____

Registered Apprentice No. _____

working under my personal supervision.

Signed *D. W. Brazelton*

Licensed Embalmer No. 4030

P. O. Address K.C., Mo.

*Hilings
Mechan
K.C., Mo.*

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, above space should be left blank.