

**FILED NOV 14 1944**  
 Registration District No. **1002**

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: **K. C. General Hospital No. 1**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **3 days**  
 (Specify whether years, months or days)  
 In this community **28 Years**

3. (a) PRINT FULL NAME **Ethel Waldman**

3. (b) If veteran, name war No. **No.** 3. (c) Social Security No. **No.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Albert J. Waldman** 6. (c) Age of husband or wife if alive **47** years  
 7. Birth date of deceased **April 16 1900**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**44 6 12** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER  
 { 12. Name **George W. Howell**  
 { 13. Birthplace **Indiana** (City, town, or county) (State or foreign country)  
 { 14. Maiden name **Emma A. Cody**  
 { 15. Birthplace **Illinois** (City, town, or county) (State or foreign country)

16. (a) Informant **Lillie Allan**

(b) Address **1211 Prospect**

17. (a) **Burial** (b) Date thereof **11 1 1944**  
 (Burial, cremation, or removal) (Month) (Day), (Year)

(c) Place: burial or cremation **Greenlawn Cemetery**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918-920 Brooklyn**

19. (a) **10-30-44** (b) **H. E. Brown**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **2611 E. 12 St.**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No.** (Yes or No)  
 If yes, name country **D**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **28**  
 year **1944** hour **11** minute **58** P. M.

21. I hereby certify that I attended the deceased from **Oct. 25**, 19 **44** to **Oct. 28**, 19 **44**  
 that I last saw her alive on **Oct. 28**, 19 **44**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of cervix with metastases** Duration

Due to

Due to

Other conditions **480**  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations  
 Of autopsy **See above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

(Specify type of place) While at work? (Specify means of injury)  
 23. Signature **A. E. Tisher** (M. D. or other)  
 Address **Med. Dir. Dept. of Health** Date signed **10-30-44**

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

**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

*J. P. Herrick*

Licensed Embalmer No. 3599

P. O. Address. *J. P. Herrick*

**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.**