

Registration District No. 149

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. Lukes
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 day (Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State. Kansas (b) County. Wyandotte

(c) City or town. Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 4000 Wood Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Gary Thomas Gabel

3. (b) If veteran, name war. no

3. (c) Social Security No. none

4. Sex Male () 5. Color or race White

6. (a) Single () (b) Widowed () (c) Married () (d) Divorced () (e) Infant ()

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

7. Birth date of deceased: November 18 1945
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19
year 1945 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from Nov 18-45
Nov 19, 1945, to _____, 19____
that I last saw him alive on 11-19-45, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days 1 If less than one day
hr. _____ min. _____

Immediate cause of death: Toxemia as result of eclampsia - mother.

Due to: of prematurity

Due to: _____

Other conditions (Include pregnancy within 3 months of death) _____

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

10. Usual occupation Infant

Major findings: 159

Of operations _____

Of autopsy 0

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Edward T. Gabel

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

14. Maiden name Betty Jane Walker

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

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) (e) Means of injury _____

23. Signature Dwight R. Florn (M. D. or other) _____
Address 1107 1/2 W. 4th St. At. Bldg. Date signed _____

16. (a) Informant's own signature Edward T. Gabel

(b) Address 4000 Wood Ave. N.C.K.

17. (a) Burial (b) Date thereof Nov. 20, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary, K.C. Kansas

18. (a) Signature of funeral director The Nugent Funeral Home

(b) Address 919 State Avenue, K. C. Kansas

19. (a) 11-20-45 (b) Waldine Holmes
(Date received local registrar) (Registrar's signature)

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

Rev. 5-17-39
U.S. GPO: 1951 O-119511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.