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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 9 1946

Registration District No. 1/7

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27150

Registrar's No. 3709

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

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. Mary's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)

In this community 49 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson, 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 3316 Michigan 8 0
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country: x

3. (a) PRINT FULL NAME: Levi Henry Halbert

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

3. (c) Social Security No.: no.

4. Sex: male 0

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Ruth D. Halbert

6. (c) Age of husband or wife if alive: unknown years

7. Birth date of deceased: May (Month) 22 (Day) 1873 (Year)

8. AGE: Years 73 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace: Illinois (City, town, or county) (State or foreign country)

10. Usual occupation: Kansas City Star Distributor

11. Industry or business: x

FATHER
12. Name: Addison M. Halbert 0
13. Birthplace: unknown, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary L. Markham
15. Birthplace: unknown 0 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Levi Halbert,
(b) Address: 3316 Michigan, Kansas City, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 8-29-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Cemetery

18. (a) Signature of funeral director: Stine & McClure,
(b) Address: 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-29-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1946 hour minute A. M.

21. I hereby certify that I attended the deceased from May 1 31, 1938 to 8-27, 1946 that I last saw him alive on 8-26, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized Carcinomatosis

Due to: Carcinoma of prostate

Due to:

Other conditions (Include pregnancy within 3 months of death): 5 1/2

Major findings:
Of operations:
Of autopsy: Autopsy

Duration

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? (e) Means of injury:

23. Signature: [illegible] M. D. (Other)

Address: 1109 Professional Building, K.C. Mo. Date signed: 8-29-46

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(If outside city or town limits, write "IN RURAL" and name township)
(c) Name of hospital or institution:
(If not in hospital or institution, give street address or location)
(d) Length of stay: In hospital or institution _____ (Specify years, months, or days)
In this community _____

2. (a) PRINT FULL NAME _____

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

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

9. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) Inside city limits? _____
(f) Outside city limits? _____
(g) Outside county? _____ (Give or No)
If yes, name county _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw him alive on _____, 19__, and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

10. Date _____

Date _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Birthplace _____ (State or foreign country)

13. Name _____

14. Maiden name _____

15. Birthplace _____ (State or foreign country)

16. (a) Father _____ (b) Date of birth _____ (Month) (Day) (Year)

17. (a) _____ (b) _____

18. (a) _____ (b) _____

19. (a) _____ (b) _____

(Informant's signature) (Address)

(Date received by Registrar) (Registrar's signature)

(Licensed Embalmer's signature on reverse side)

PHYSICIAN WRITE PLAINLY—USE LEADING BLACK INK—MAKE A PERMANENT RECORD

FOLDER EMBALMER

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 Robert H Reed

Licensed Embalmer No. 3743

P. O. Address N 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, fact should be so stated above.