

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30183

State File No.

Registrar's No. 3853

Registration District No. SEP 25 1946

Primary Registration District No. 1002

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 6 days
(Specify whether years, months or days)

In this community unknown

3. (a) PRINT FULL NAME Harry Cabell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March 6, 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>5</u>	<u>5</u>	hr. min.

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

10. Usual occupation Laundry helper

11. Industry or business Not known

MOTHER FATHER {

12. Name Not known 9

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

14. Maiden name Not known 9

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 1

17. (a) Ke Quat Inc (b) Date thereof 8-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ke Gen Hosp

18. (a) Signature of funeral director Wm A. Johnson

(b) Address City Mortician

19. (a) 9-10-46 (b) Geraldine Helms
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 40

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

(d) Street No. 421 1/2 Westport. Rd.
(If rural, give location) 38

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11
year 1946 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from July 5, 1946, to Aug. 11, 1946
that I last saw him alive on Aug. 11, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy None

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? _____

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

23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 8-13-46

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.....

Blaine E. Wheelert

Licensed Embalmer No. *4075*

P. O. Address.....

L.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.