

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

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town RURAL Gallatin Sup  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
R.R.#4-OAKWOOD ADDITION-NORTH KANSAS CITY  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 44 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 240

(c) City or town RURAL - NORTH KANSAS CITY  
(If outside city or town limits, write "RURAL".)

(d) Street No. R.R.#4-OAKWOOD ADDITION  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. NO

3. (a) PRINT FULL NAME MRS. R. BELLE GABELMAN

3. (b) If veteran, name war No

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 11<sup>TH</sup> year 1944 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 15, 1944, to July 11, 1944  
that I last saw her alive on July 11, 1944  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. FRED GABELMAN 6. (c) Age of husband or wife if alive 9 years

7. Birth date of deceased JULY-9-1869  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to Arterio Sclerosis years

Due to Chronic Myocarditis

Other conditions (Include pregnancy within 3 months of death) 930

8. AGE: Years Months Days If less than one day

75 0 2 hr. min.

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

10. Usual occupation AT HOME

Major findings: Of operations. 930

Of autopsy. 930

PHYSICIAN 930

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business

12. Name GEORGE W. TURPIN

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

14. Maiden name MELISSA S WARE

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

16. (a) Informant MRS BYRON E. MINTONYE

(b) Address LEES SUMMIT, MISSOURI R.R.#3

17. (a) BURIAL (b) Date thereof JULY-13-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY MO.

18. (a) Signature of funeral director D. Newcomer here

(b) Address KANSAS CITY, MISSOURI

19. (a) July 12-1944 (b) Arthur H. Henry  
(Date received local registrar) (Registrar's signature)

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? NO.

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature John L. Lapp (M. D. or other) Ind.  
Address 1314 Professional B Date signed July 12-44

1021

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-25-44

1347 Anatomical Body  
1-5

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 A. C. Newcomer Jr.

Licensed Embalmer No. 4043

P. O. Address A. 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.