

Registration District No. 349

Primary Registration District No. 6180

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Sullivan

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community most of life
years, months or days

3. (a) PRINT FULL NAME JACOB HAMPTON CABLE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Alice Brown Cable

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

7. Birth date of deceased 2 20 1853
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Wolf Co Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Jacob Cable

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Hobbs

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Cable

(b) Address Winigan Mo.

17. (a) Burial (b) Date thereof 6 3 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Price Cem.

18. (a) Signature of funeral director Glenn E. Hunt & Son

(b) Address Green City Mo.

19. (a) Jane 2446 (b) Laura M. Shaw
(Did not receive local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan ¹⁰⁵

(c) City or town Winigan ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? no (Yes or No) ⁰
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1946 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from MAY - 26 1946 to JUNE - 1 1946
and that death occurred on the date and hour stated above.

that I last saw him alive on MAY 31 1946

Immediate cause of death CARCINOMA OF LEFT SIDE OF FACE & NECK INVOLVING
THROAT - EAR NECK
ETC

Due to _____

Due to _____

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

Major findings: 53
Of operations _____

Of autopsy _____

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 M. Schurr (M. D. or other) ⁰
Address Green City Mo Date signed 6-3-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 7-46-1261

Date Filed JUL 3 1946

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.