

No. 2
-5-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30140
3936

Registration District No. 149 Primary Registration District No. 1002 State File No. Registrar's No.

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)
5 miles.
(d) Length of stay: In hospital or institution _____ (Specify whether)
one day
In this community _____
years, months _____ days

3. (a) PRINT FULL NAME Andrew LeRoy Abel
3. (b) If veteran, name war No 3. (c) Social Security No. No
4. Sex m-d 5. Color of race wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ruth Abel 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Apr 11 1875
(Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Circleville Kansas
(City, town, or county) (State or foreign country)
10. Usual occupation Night Watchman

11. Industry or business _____
12. Name Arch. D. Abel
13. Birthplace Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Cynthia M. Commas
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Gen. Harp
(b) Address City
17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 9-19-46
(Month) (Day) (Year)
(c) Place: burial or cremation CIRCLEVILLE Circleville, Mo
18. (a) Signature of funeral director Ms. G. L. Fowler
(b) Address KC Mo
19. (a) 9-17-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County 999
(c) City or town Holton (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 17
year 1946 hour 9 minute 45 A.M.
21. I hereby certify that I attended the deceased from 9-17-1946 to 9-17-1946
that I last saw him alive on 9-17-1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) g/a
Major findings: Of operations _____
Physician _____
See above
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. Harp (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 9-17-46

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

Dr. Luman

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 *C. H. Neise*.....

Licensed Embalmer No. *2570*.....

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, fact should be so stated above.