

FILED JAN 20 1948

Registration District No. **189**

Primary Registration District No. **1002**

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. 2**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **4 DAYS**  
 In this community **40 YRS.**  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**  
 (c) City or town **KANSAS CITY**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **717 1/2 INDEPENDENCE AVE.**  
 (If rural, give location)  
 (e) Citizen of foreign country? **NO** (Yes or No)  
 If yes, name country:

3. (a) PRINT FULL NAME **DANIEL WHITENHILL**

3. (b) If veteran, name war **World War #2** 3. (c) Social Security No. **no**

4. Sex **MALE** 2 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **MARRIED**  
 6. (b) Name of husband or wife **Lydia Whitenhill** 6. (c) Age of husband or wife if alive **60 years**  
 7. Birth date of deceased **JANUARY 23, 1895**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>52</b>	<b>11</b>	<b>14</b>	hr. min.

9. Birthplace **OWEN KENTUCKY**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **COMMON LABORER**

11. Industry or business

MOTHER FATHER {  
 12. Name **DANIEL WHITENHILL SR.**  
 13. Birthplace **OWEN KENTUCKY**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Lydia JACKSON**  
 15. Birthplace **OWEN KENTUCKY**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **LYDIA Whitenhill (mother)**  
 (b) Address **717 1/2 INDEPENDENCE AVE.**

17. (a) **Burial** (b) Date thereof **10-48**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Highland Cem**

18. (a) Signature of funeral director **H. B. Moore**

(b) Address **1820 E 15 st**

19. (a) **1-9-48** (b) **St Pauline Holman**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **7**,  
 year **1948** hour **10:** minute **00 A.M.**

21. I hereby certify that I attended the deceased from **JANUARY 3, 1948**, to **JANUARY 7, 1948**  
 that I last saw him alive on **JANUARY 7, 1948**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **FAR ADVANCED PULMONARY TUBERCULOSIS (X-RAY ONLY)** Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **13 1/2** PHYSICIAN

Of autopsy..... 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 piece) (e) Manner of injury

23. Signature **Dr. Frank [Signature]** (M. D. or other) **M.D.**  
 Address **GENERAL HOSPITAL NO. 2** Date signed **1/8/48**

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

**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 AB Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 st

**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.**