MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12519

MAY 26 19

1. PLACE OF DEATH

County Jackson — Registration District No. 398 — File No.

Township Blue — Primary Registration District No. 5554 — Registered No. 127

City Independence (No. 8717 Thompson St. Ward)

2. FULL NAME ~~Mrs. W. M. Fowler~~ Mattie May Fowler

(a) Residence. No. 8717 Thompson St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: W. M. Fowler

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 31 - 1877

7. AGE: YEARS 52 — MONTHS 10 — DAYS 18 — IF LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: A. P. Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Margaret Ellis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Mrs. W. M. Fowler
(Address) 8717 Thompson Ave.

15. FILED 4-21, 1930 F L Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 19 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to Apr 19, 1930 that I last saw her alive on Apr 18, 1930, and that death occurred, on the date stated above, at 1.50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Endocarditis with decompensation
92B
9SB (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10a (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas E Nickson, M. D.
4-21, 1930 (Address) Independence Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Syracuse, Mo. — DATE OF BURIAL: Apr 21 1930

20. UNDERTAKER: Mrs. C. L. Foster — ADDRESS: K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

M.A.Bldg.
Independence 3100
610 N. River 101