

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

REG. 5-17-39 I 19131

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.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4062**

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: **5921 Paseo**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **40 years**
(Specify whether 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. **5921 Paseo**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (c) PRINT FULL NAME **Mrs. Nancy M. Rowe**

8. (b) If veteran, name war **- No** 3. (c) Social Security No. **- No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **Walter Rowe** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct. 3, 1857**
(Month) (Day) (Year)

8. AGE: Years **82** Months **0** Days **19** If less than one day hr. _____ min. _____

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

10. Usual occupation **At home**

11. Industry or business _____

12. Name **Joseph Cunningham**

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

14. Maiden name **Don't know**

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

16. (a) Informant's own signature **Harold Rowe**

(b) Address **Fairmount, Missouri**

17. (a) **Burial** (b) Date thereof **Oct. 24, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **104 W. 42nd St., K.C., Mo.**

19. (a) **10/23/39** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **22,** year **1939** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Oct 15 1939** to **Oct 22 1939** and that I last saw him alive on **Oct 21 1939** and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia acute**
 Due to **acute case 10/16**
 Due to **advanced age**

Other conditions **Advanced age**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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 **M. M. Browne** (M. D. or other) _____
 Address **937 S. 9th St. 1220** Date signed **10/23/39**

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 CLARENCE W. CHURCH

Registered Apprentice No. _____

working under my personal supervision.

Signed Clarence W. Church

Licensed Embalmer No. 3473

P. O. Address H. C. 760

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, above space should be left blank.