

Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1507 East 8 St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **one week**
years, months or days)

8. (a) PRINT FULL NAME **James P. Rowan** **5077**
8. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mamie Rowan** 6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **July 24 1866**
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Store Clerk**

11. Industry or business _____

MOTHER FATHER
12. Name **Jim Rowan**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Heddie Wiseman**
15. Birthplace **Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mamie Rowan**
(b) Address **67507 East 8 St.**

17. (a) **Removal** (b) Date thereof **June 1 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Salem Arkansas**

18. (a) Signature of funeral director **Mrs. C.L. Forster**
(b) Address **918 Brooklyn**
June 2, 1940

19. (a) _____ (b) **M. M. Cowie**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Arkansas** (b) County _____
(c) City or town **Salem Ark.**
(If outside city or town limit, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31**
year **1940** hour **11** minute **A.** M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pulmonary Edema** Duration _____
Due to _____
Due to **Hypertensive Myocardium**

Other conditions **935**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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 **James P. Rowan** (M. D. or other) _____
Address _____ Date signed _____

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

Dwight C. Browning

Licensed Embalmer No.

2724

P.O. Address

H. C. 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, above space should be left blank.