No. 2
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X21492

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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31134

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3697

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 #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-15-40-9-19-40 (Specify whether

In this community 12 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City (If outside city or town limits write "RURAL")

(d) Street No. 1918 E. 26th St. 4th Fl. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Jesse Fowler

3. (b) If veteran, name war No

3. (c) Social Security No. 487-05-4809

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy Fowler

6. (c) Age of husband or wife if 35 alive ~~Unknown~~ years

7. Birth date of deceased Feb (Month) 22 (Day) 1903 (Year)

8. AGE: Years 37 Months 6 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace Americus (City, town, or county) Georgia (State or foreign country)

10. Usual occupation STeel Worker

11. Industry or business Sheffield Steel Works

FATHER
12. Name John Fowler
13. Birthplace Americus (City, town, or county) Georgia (State or foreign country)

MOTHER
14. Maiden name Amanda Rodgers
15. Birthplace Americus (City, town, or county) Georgia (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Highland (Burial, cremation, or removal) (b) Date thereof Sept 23, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City MO

18. (a) Signature of funeral director E. Sterling Bills

(b) Address 1811 E. 12th St. K.C. MO.

19. (a) 9-23-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 19 year 40 hour 12 minute 10 A.M.

21. I hereby certify that I attended the deceased from 9-15-, 1940 to 9-19-, 1940 that I last saw him alive on 9-19-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebrospinal Meningitis	
Due to Mastoiditis	
Due to	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 9-20-40

(Licensed Embalmer's Statement on Reverse Side)

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 E. Sterling Bills

Licensed Embalmer No. 3178

P. O. Address 1811 E. 12th St, K.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
21-40
X22633

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31134

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3697-

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DEACESED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Jesse Fowler -

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

4. Sex M | 5. Color or race B | 6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife .....

6. (c) Age of husband, or wife, if alive ..... years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 9/23/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19 - 1940
year ..... hour ..... minute ..... M.

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

Immediate cause of death Cerebro spinal meningitis — Duration

Due to Mastoiditis -

Due to (Meningococcus)

Other conditions
(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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY