

APR 3 1941
Registration District No. 198

Primary Registration District No. 301

Registrar's No. 35

1. PLACE OF DEATH:
 (a) County Clay
 (b) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
524 Caldwell
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 all of life (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Reta Fay Bowers
 8. (b) If veteran, name war Child 3. (c) Social Security No. ✓
 4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced SD
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 3 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 2 2 hr. min.
 9. Birthplace Kansas City - Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____
 MOTHER FATHER
 12. Name George Bowers
 13. Birthplace Ray Co. Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Faynes Schoening
 15. Birthplace Ray Co. Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Bowers
 (b) Address Excelsior Springs, Mo.
 17. (a) Burial (b) Date thereof Mar 6 - 41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lynian Cemetery
Colander Park
 18. (a) Signature of funeral director _____
 (b) Address Excelsior Springs, Mo.
 19. (a) Mar 5 - 1941 (b) M. M. Cracker
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Clay
 (c) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL")
 (d) Street No. 524 Caldwell
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5
 year 1941 hour 2:30 minute A. M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary
Intestinal Obstruction
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
 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) Intestinal Obstruction
 (b) Date of occurrence Nov. 5th 1941
 (c) Where did injury occur? at Home 524 Caldwell
 (City or town) (County) (State) City
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home
 (Specify type of place)
 (e) Means of injury _____
 23. Signature R. W. Cracker (M. D. or other)
 Address Excelsior Springs, Mo. Date signed 3-5-41

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

122A

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-2-41

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 Claude Richard

Licensed Embalmer No. 2757

P. O. Address Exelior Spring

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.

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Way

(b) City or town Excelsior Spgs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital of institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Reta Fay Powers

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

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

20. DATE OF DEATH: Month Mar day 5
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

8. AGE: Years 1 Months 2 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

Due to Intestinal Obstruction

Due to Locked Bowel N.M.D.

Other conditions _____
(Include pregnancy within 5 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN 12712

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 R. W. Prather (M. D. or other) _____

Address Excelsior Spgs Date signed _____

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

SUPPLEMENTARY

S-10401 1941