

Registration District No. **371**

Primary Registration District No. **1002**

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 _____
In this community **Four hrs.** **0** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Gentry Owens**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Dont know** 6. (c) Age of husband or wife if alive **unk** years

7. Birth date of deceased **Dec 15 1871**
(Month) (Day) (Year)

8. AGE: **70** Years **10** Months **11** Days If less than one day hr. min.

9. Birthplace **Texas** **Dont know**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer** **I.W.O.A.**

11. Industry or business **Dont know**

12. Name **Robert Owens**

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

14. Maiden name **Dont know**

15. Birthplace **Dont know**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. P. Owens**

(b) Address **2525 N. Allis, N.C.K.**

17. (a) **Burial** (b) Date thereof **10-8-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **[Signature]**

(b) Address **10/8/41**

19. (a) **10/8/41** (b) **M. M. Chow**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **1613 Kansas Ave**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **6** year **41**
hour _____ minute _____ M.

21. I hereby certify that I read and have deceased from **11:50 A.M.**
_____ 19____

that I last saw him/her alive on _____ 19____

and that death occurred on the date and hour stated above.

Important cause of death _____ Duration _____

Acute generalized peritonitis

ruptured diverticulitis of the colon

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **1231**

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) (c) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **3**
Address **W. P. Owens** Date signed _____

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

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 *C. A. Heat*
Licensed Embalmer No. *2710*
P. O. Address *W. C. 740.*

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

If this body is not embalmed, fact should be so stated above.