

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 19 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9749  
1555

State File No. ....

Registrar's No. ....

Registration District No. 149

Primary Registration District No. 1602

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:  
Convalescent Home 1809 Myrtle  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Months  
(Specify whether  
In this community 1 6 years  
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. 2410 Spruce  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Madge C. Cowdery

3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife George Cowdrey  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Aug. 22 1886  
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 15  
If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name Unknown  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Waller

(b) Address 7236 Agnes

17. (a) Burial (b) Date thereof 4/8/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

19. (a) 4-8-44 (b) D. E. Brown  
(Date received for registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th,  
year 1944 hour 7 minute 45 A. M.

21. I hereby certify that I attended the deceased from 3/25 1944 to 4/7 1944  
that I last saw him alive on 4/6 and that death occurred on the date and hour stated above.

Immediate cause of death Basenoma cervix with metastasis  
Due to metastasis

Due to 480  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none  
XRay - Basenoma cervix  
Of autopsy none

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 D. E. Brown M. D. or other ✓  
Address 4800 E. 15th Date signed 4/24/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

*John B. Camp*  
.....

Licensed Embalmer No. *2955*

P. O. Address.....

*K.C. Mo*

MAY 19 1948

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, fact should be so stated above.