

**FILED JUN 13 1946**  
Registration District No. **59**

Primary Registration District No. **4094**

Registrar's No. **76**

**1. PLACE OF DEATH:**

(a) County Cass  
(b) City or town Garden City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(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)

3. (a) PRINT FULL NAME Lida May Stowers

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert Stowers 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 21 1872  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 9 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Garden city Mo 92  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W N Slye

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

14. Maiden name Mary Smith

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

16. (a) Informant Robert Stowers  
(b) Address Garden City

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

(c) Place: burial or cremation Garden City

18. (a) Signature of funeral director Robert Arnold  
(b) Address Creechton Mo.

19. (a) June 3, 1946 (b) Laura J. Jones  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Cass 19  
(c) City or town Garden City 0  
(If outside city or town limits write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 30  
year 1946 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from Sept. 7 1945, to May 30 1946  
that I last saw her alive on May 30 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Due to Vascular disease

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None  
Of autopsy \_\_\_\_\_

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 Frank B. Ellis (M. D. or ~~other~~ M.D.)  
Address Ellis Building Garden City, Mo Date signed May 31, 1946

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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**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.....

*Robert Amos*

Licensed Embalmer No.

*3621*

P. O. Address

*Exington N*

**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. 59

Primary Registration District No. 4094

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Haden city  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (years, months or days)

3. (a) PRINT FULL NAME Lida May Stouen  
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 M  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased Sept 2  
(Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

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) Rauca J. Jones  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1946 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 \_\_\_\_\_

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

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) \_\_\_\_\_  
(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) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

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

880

16010