

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013578

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 30

5. 300
1-57

6002
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>3-258</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration INSTITUTION <u>Hospital</u>		Length of stay in lb <u>50 days</u>	d. STREET ADDRESS (If outside, give location) <u>1416 Euclid</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>BOWIE</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1958</u>
5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Shiner</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Milford, Texas</u>
10c. FATHER'S NAME <u>John Bowie</u>		13b. MOTHER'S MAIDEN NAME <u>Susie Buckingham</u>	14. NAME OF HUSBAND OR WIFE <u>- -</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>495 07 7036</u>	17. INFORMANT <u>VA Hospital records</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the left lung with wide spread involvement, inoperable</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>163 X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. <u>VA</u> attended the deceased from <u>February 11, 1958</u> to <u>April 2, 1958</u> Death occurred at <u>1:40</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <u>Clyde V. Kern, M.D.</u> (Degree or title) <u>Chief, Tuberculosis Service</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>4-3-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-4-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas, Texas</u>
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-8-58</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

(Licensed Embalmer's Statement on Reverse Side)



JUN 17 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ludell Jarman*

Licensed Embalmer No. *4589*
P. O. Address *East Springs*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.