

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028471

FILED VS SEP 9 1959

Registration District No. 72

Primary Registration District No. 3013

Registrar's No. 149

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u> Length of stay in lb <u>6 mos</u>		c. CITY OR TOWN <u>NORTH 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 INSTITUTION <u>1031 E 24<sup>TH</sup> AVE</u>		d. STREET ADDRESS (If outside, give location) <u>1031 E 24<sup>TH</sup> AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lonnie</u> Middle <u>Albert</u> Last <u>Rowe</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wabash R.R.</u>		11. BIRTHPLACE (City and state or country) <u>MT. Pleasant MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U-SA</u>
13a. FATHER'S NAME <u>Thomas B. Rowe</u>		13b. MOTHER'S MAIDEN NAME <u>MARY CAYTON</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA Rowe</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MRS. J.C. MYERS 1031 E 24<sup>TH</sup> AVE</u>		

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>ACUTE RESPIRATORY FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMATOSIS</u> <u>6 mo</u>	
DUE TO (c) <u>CARCINOMA OF PHARYNX</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____, Month _____, Day _____, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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. I attended the deceased from <u>3-20-59</u> to <u>8-31-59</u> and last saw her/him alive on <u>8-31-59</u> Death occurred at <u>3 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Daniel Boone MD</u> (Degree or title)		22b. ADDRESS <u>2025 SWIFT NKCL6, MO 63109</u>		22c. DATE SIGNED <u>8/31/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-2-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Ridge Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Stanbery MO</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer, N.K.S. MO</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hodgson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS. SE. 28 1959

MAR 29 1960

181191

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John M. Halbeck

Licensed Embalmer No. 4949  
P. O. Address. No. Kansas

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.