

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001361

FILED VS FEB 8 1961 AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 268

STATE FILE NUMBER

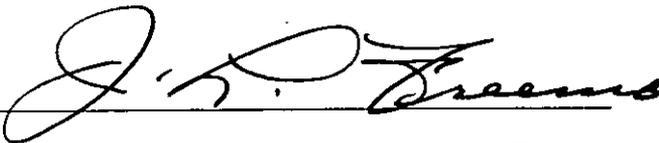
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|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | Length of stay in lb <u>50 YRS.</u> | 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 INSTITUTION <u>General Hosp.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>750W 47th</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry G. Fowler</u> | | | 4. DATE OF DEATH Month Day Year <u>1 15 61</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>9-19-1874</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED INSURANCE ADJUSTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>ALBERT W. FOWLER</u> | | 13b. MOTHER'S MAIDEN NAME <u>ELIZABETH JONES</u> | | 14. NAME OF HUSBAND OR WIFE <u>BERTHA FOWLER</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. BERTHA FOWLER K.C. Mo.</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>Bilateral Broncho pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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. I attended the deceased from <u>11-3-60</u> to <u>1-15-61</u> and last saw him alive on <u>1-15-61</u> Death occurred at <u>11:49 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | | 22b. ADDRESS <u>2400 Cherry</u> | | 22c. DATE SIGNED <u>1-17-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | 23b. DATE <u>1-18-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD</u> | | 23d. LOCATION (City, town, or County) (State) <u>KANSAS CITY, MO.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>FREEMAN MORTUARY K.C. Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>1-17-61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Frank Ellis
SHOULD READ
ITEM NO.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 2939

P. O. Address F. O. Mo.

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.