

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2134 - 62-015439
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

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

FILED APR 30 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Leawood	
Length of stay in 1b 1 month		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		d. STREET ADDRESS (If outside, give location) 2008 W. 86 Terrace	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last CARL AMOS ROWLAND			4. DATE OF DEATH Month Day Year April 15, 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-16-90
9. AGE (last birthday) 72		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) Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	11. BIRTHPLACE (City and state or country) Gibson City, Illinois
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Amos Rowland	
13b. MOTHER'S MAIDEN NAME Clara Hawley		14. NAME OF HUSBAND OR WIFE Elizabeth M. Rowland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. —	
17. INFORMANT VA Hospital Records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Recent hemorrhage left cerebellar hemisphere			
DUE TO (b) Thrombocytopenia and soft tissue infiltrates			
DUE TO (c) Acute myeloblastic leukemia			
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 VA March 14, 1962 to April 15, 1962 and last saw him/her on April 15, 1962 . Death occurred at 6:50 pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T. J. FRITZLEN M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	
22c. DATE SIGNED 4-16-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Apr. 18, 1962	23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 4-17-62	26. REGISTRAR'S SIGNATURE Ruth H. Long

USE BLACK INK
OR
TYPEWRITER RIBBON

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. 4998

P. O. Address K.C., 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.