

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027081

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3493
FILED JUL 25 1962

VS 300
Rev. 4/59

1
2 3538
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4 0
5 3
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7 0
8 0
9 4200
10
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12 260
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF M.D. MORTLAND, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 50 yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Beacon Hill Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1109 East Armour Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAY Middle G Last FWLER			4. DATE OF DEATH Month July Day 1 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-8-1884
9. AGE (last birthday) 78		IF UNDER 1 YEAR Months 78 Days	IF UNDER 24 HR Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during 1 yr. or work 100% of last yr. if retired) Retired - Supervisor		10b. KIND OF BUSINESS OR INDUSTRY S.W. Bell Telephone	11. BIRTHPLACE (City and state or country) Sedalia, Mo.
12. CITIZENSHIP OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John G. Fowler	
13b. MOTHER'S MAIDEN NAME Jane Brereton		14. NAME OF HUSBAND OR WIFE J.G. Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address J. Garnett Fowler, 4211 Virg. K.C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 min.
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 _____ a.m. _____ p.m. 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 Dec. 31, 1961 to 7-1-62 and last saw ^{her} him alive on June 21, 1962 Death occurred at 2:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) M. Donald M. Land M.D.		22b. ADDRESS 4320 Wornall Rd. Hc Mo.	22c. DATE SIGNED 7-2-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 3, 1962	23c. NAME OF CEMETERY OR CREMATOR Mt. Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR ADDRESS D.W. Newcomer's Sons 1331 Brush Ck. Kan. City, Mo.		25. DATE RECD. BY LOCAL REG. 7-3-62	26. REGISTRAR'S SIGNATURE Ruth H Long

USE BLACK INK OR TYPEWRITER RIBBON

Dr. W. Donald McFarland
12,100.500
4320 Mainwell Road - 1332
Room

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 Chester H. Brown

Licensed Embalmer No. 4931

P. O. Address _____

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.