MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11654

1. PLACE OF DEATH

County: Jackson — Registration District No. 399 — File No.

Township: Kaw — Primary Registration District No. 1002 — Registered No. 1445

City: Kansas — (No. St Marys Hospital St. Ward)

2. FULL NAME Mondell Norwood Cowart

(a) Residence. No. 1310 Troost St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-17-1922

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	4	4	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Alma
(STATE OR COUNTRY) Arkansas

PARENTS

10. NAME OF FATHER Grady Cowart.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Alma
(STATE OR COUNTRY) Arkansas
12. MAIDEN NAME OF MOTHER Violet Meadows
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Alma
(STATE OR COUNTRY) Arkansas

14. INFORMANT Violet Cowart
(Address) 1310 Troost

15. FILED 4/6, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr-6 1927

17. I HEREBY CERTIFY, That I attended deceased from 3/6, 1927, to 4/5, 1927, that I last saw him alive on 4/5, 1927, and that death occurred, on the date stated above, at 4:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Abscess
(Rt temporal Lobe Abscess)
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Mastoiditis (Acute)
(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1310 Troost
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3/8-27
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) L. M. Galloway M. D.
4/6, 1927 (Address) 615 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Alma Arkansas — DATE OF BURIAL: Apr-7 1927

20. UNDERTAKER: Mrs. C. L. Forster — ADDRESS: 918 Brooklyn

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 1446

City Kans City (No. ....., ... St. ..... Ward)

2. FULL NAME Mondell Norwood Cowart

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/6, 1927 M M Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 6 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain abscess (Rt temporal lobes abscess
Streptococcic
Not traumatic
Stophlococcic
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Mastoiditis acute
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 86B
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) L M Callaway, M.D.
4/6, 1927 (Address) 615 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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