

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

33683

1. PLACE OF DEATH

County.....Jackson..... Registration District No.....
Township.....Kaw..... Primary Registration District No.....
City.....Kansas City..... (No. 3724 Bell)..... St..... Ward.....

File No.....
Registered No. 83-1
Date 1927 Ward.....

2. FULL NAME Eather I. Cowles

(a) Residence No. 3724 Bell..... St., 5 Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22, 1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
83 - - -

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)..... Pa.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Lyman Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Don't Know

14. INFORMANT Mrs. Ed P. Furr
(Address) 3724 Bell

15. FILED 11-23 1927 M. M. Lawrence
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1927, to Nov 22 1927 that I last saw him alive on Nov 22 1927, and that death occurred, on the date stated above, at 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Thrombosis internal iliac (right)

CONTRIBUTOR (duration) yrs. mos. da. 5
Arteriosclerosis
SECONDARY Chronic (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. O. Chambers, M.D.
11-22-27 (Address) 800 Beattie 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 St. Joseph, Mo DATE OF BURIAL Nov 24 19 27

20. UNDERTAKER P. V. Lindsay
ADDRESS 3811 Broadway

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

