

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.

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

Do not use this space.

1581

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City K. C. Mo. (No. St. Marys Hosp.)

Registration District No. 399  
Primary Registration District No. 1008

File No. 2811  
Registered No. 2811  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Harper Dowell  
(a) Residence No. 306 N. 2nd St. St. 10 Ward \_\_\_\_\_

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 M. 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-14-1861

7. AGE YEARS 71 MONTHS 3 DAYS 6 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. no Pacific  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. conductor  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ If full time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

13. NAME P. J. Dowell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Sarah Bishop

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) 306 N. 2nd

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 1-20 1933

19. UNDERTAKER (ADDRESS) Mrs. C. J. Foster  
H. C. 2nd

20. FILED Jan 20 1933 M. M. Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20 1933

22. I HEREBY CERTIFY, That I attended deceased from Jan 18 1933 to Jan 20 1933  
I last saw him alive on Jan 20 1933. Death is said to have occurred on the date stated above, at 4 1/2 m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 1-19-33  
not 2d time, one 2 yrs ago  
(case)  
Other contributory causes of importance: 1-19-33  
Pneumonia

Name of operation J. J. W. Date \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) E. A. Greenway, M. D.  
(Address) 800 N. 2nd St. K. C. Mo.

Dr.