

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.

Registration District No. 399 Primary Registration District No. 1002

JAN 13 1940

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Research Hospital 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 Days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Miss Della Bowen 5th fl
 8. (b) If veteran, name war No
 8. (c) Social Security No. No

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 22, 1858
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Plymouth Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name Jeremiah Bowen
 13. Birthplace Dayton Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Wickizer
 15. Birthplace Lancaster Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Della Bowen
 (b) Address Mansfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-39
(Month) (Day) (Year)
 (c) Place: burial or cremation Rockville Mo

18. (a) Signature of funeral director Auto Deuro & Son
 (b) Address Schell City Mo. 361
 19. (a) Dec. 20, 1939 (Date received local registrar) (b) M. M. Crowl (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo 1 (b) County _____
 (c) City or town Rockville Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
 year 1939 hour 3 minute 32 p. M.
 21. I hereby certify that I attended the deceased from Dec. 10, 1939 to Dec 20, 1939, that I last saw her alive on Dec 20, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Intestinal Obstruction
 Due to Carcinoma of Rectum
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: Obstructive carcinoma of rectum
 Of operations _____
 Of autopsy Rectal Intestinal obstruction

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? 1 (Specify type of place) _____
 Means of injury _____
 23. Signature Leon Schieler (M. D. or other) _____
 Address Kansas City, Mo Date signed 12-20-39

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Marion M. Lewis

Licensed Embalmer No. *3084*

P. O. Address *Schell city, 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 this body is not embalmed, above space should be left blank.