

Registration District No. _____ Primary Registration District No. 1002

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:
3617 Forest 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Unknown
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri, (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3617 Forest
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No. years.

3. (a) PRINT FULL NAME 620 Mrs. Elizabeth Bowers
3. (b) If veteran, name war No.
3. (c) Social Security No. No.
4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife T. D. Bowers
6. (c) Age of husband or wife if alive X years
7. Birth date of deceased May 14 1852
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 26th
year 1940 hour 11:35 minute P. M.
21. I hereby certify that I attended the deceased from Feb. 24
1940, to _____, 19____;
that I last saw her alive on Feb 24 - 1940, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
87 9 12 _____ hr. _____ min.
9. Birthplace Indiana
(City, town, or county) (State or foreign country)

Immediate cause of death Chronic myocarditis
Due to Arterio Sclerosis 93c
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation at home
11. Industry or business X
MOTHER FATHER { 12. Name Ferrel McGovern 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

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? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant's own signature Mrs. John S. Fields
(b) Address 3617 Forest, Kansas City, Mo.
17. (a) Burial (b) Date thereof 2-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis, Mo.
18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 2-28-40 (b) M. M. Orvine
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other)
Address 604 Maple St. S.E. W.S. Date signed 2-27-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 6-17-39

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.

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

Dr. Hobbs
Argyle Bldg
742 5037

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address W. C. 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.