

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 990

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: General Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2-21-40-2-23-40
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT
FULL NAMEJohn Bowman557

3. (b) If veteran,

name war None

3. (c) Social Security

No. None4. Sex Male5. Color or
race Negro6. (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

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

about 65

hr. min.

9. Birthplace

Brunswick

(City, town, or county)

None

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

Nelson Bowman

13. Birthplace

Ky.

14. Maiden name

Unknown

15. Birthplace

Unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Record Clerk

(b) Address

General Hospital #217. (a) burial
(Burial, cremation, or removal)(b) Date thereof 3/4/40

(Month) (Day) (Year)

(c) Place: burial or cremation

Highland Cemetery

18. (a) Signature of funeral director

1729 Lydia

(b) Address

3-4-40

(Date received local registrar)

(b)

M. Vn. Jerome

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1108 Vine St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 23
year 40 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from
2-21- 19 40 to 2-23- 19 40
that I last saw him alive on 2-23- 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death

Uremia

Duration

Due to

Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Above Mentioned

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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)

(Specify means of injury)

23. Signature

General Hospital #2

(M. D. or other)

Date signed 2-26-

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

Isaac Jerome Maxlowe

Licensed Embalmer No.

3994

P. O. Address

1170 E 23rd

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.