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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No.

13725

1437

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
3719 Gillham Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME JOHN M. COWHERD 630

3. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Fannie B. Cowherd 6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 31 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 0 If less than one day hr. min.

9. Birthplace Boyle County Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Retired
Real Estate

11. Industry or business 9
MOTHER FATHER { 12. Name No Record
13. Birthplace " "
14. Maiden name No Record
15. Birthplace " "

16. (a) Informant Dr. Jos. B. Cowherd
(b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof 4-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director J. M. Wagner
(b) Address Kansas City, Mo.

19. (a) April 2, 1940 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

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. 3719 Gillham Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 31st
year 1940 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from March 1st
1940 to March 31st, 1940;
that I last saw him alive on March 31st, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic
Pneumonia Duration 4 days

Due to Following fracture
of left hip February 26th
1940

Other conditions 10/10
(Include pregnancy within 3 months of death) 10

PHYSICIAN
Major findings: none (X-ray was made)
Of operations none
Of autopsy none
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) acc
(b) Date of occurrence 2-26-1940
(c) Where did injury occur? In his own room 3719 Gillham
(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 Fall
23. Signature Robert J. Island M.D. (M. D. or other) Fall
Address 315 Alameda Road KCMo Date signed 4/1/1940

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

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 Cecil P. Mathew
Licensed Embalmer No. 3807
P. O. Address D. C. MD.

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.