

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

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. _____ Primary Registration District No. _____

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: Children's Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community Lifetime
years, months or days)

8. (a) PRINT FULL NAME Samuel Stowell 340
3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex Male 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 Apr. 28, 1928
(Month) (Day) (Year)

8. AGE: Years 12 Months 2 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Estarda, Oregon
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin Stowell 0
13. Birthplace North Dak. (State or foreign country)
14. Maiden name Sarah Wagner
15. Birthplace Independence, Missouri (State or foreign country)

16. (a) Informant's own signature Benjamin Stowell
(b) Address 511 W. Pacific

17. (a) Burial (b) Date thereof 7/21/1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mound Grove Cem.

18. (a) Signature of funeral director Cato & Speaks
(b) Address Independence, Mo.

19. (a) July 20, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 511 W. Pacific (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1940 hour 5 minute 0 M.
21. I hereby certify that I attended the deceased from July 18, 1940 to July 18, 1940
that I last saw him alive on July 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to Acute glomerulonephritis
Due to Terminal broncho-pneumonia
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy Pne
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? _____

23. Signature M. M. Crowe (Specify type of place) _____ (M. D. or other) _____
Address 1316 1/2 W. 12th St. (e) Means of injury 1
Date signed July 18-40

107a

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 me

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

Signed Roland B. Speaks

Licensed Embalmer No. 3604

P. O. Address Independence, 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.

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

Mar 18 1940
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No.
 (b) Township Ko. Primary Registration District No. Registered No. 2951
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Stowell SAMUEL
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED July 20 1940 M. M. Croome Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18 1940

22. HEREBY CERTIFY, That I attended deceased from July 18 1940 to July 18 1940. I last saw him alive on July 8 1940. Death is said to have occurred on the date stated above, at m.

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

Scarlet Fever

Date of onset

Other contributory causes of importance:

Acute Glomerular Nephritis
General pneumonia

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? Yes

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?
 If so, specify

(Signed) M. B. Soderberg, M. D.

(Address) 1316 Prof Bldg.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

5-24291

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.....

Licensed Embalmer No.....

P. O. Address.....

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.