

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.

FILED AUG 14 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24376
2986
Registrar's No. _____

Registration District No. 399 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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7-18-40-7-25-40
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME James Owens
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 7, 1853
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days ? If less than one day _____ hr. _____ min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business _____
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
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 #2
17. (a) burial (b) Date thereof 7/27/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery
18. (a) Signature of funeral director W. M. Crow
(b) Address 1729 Lydia
19. (a) July 27, 1940 (Date received local registrar)
(b) W. M. Crow (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. 2444 Tracy
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 25
year 40 hour 6 minute P. M.
21. I hereby certify that I attended the deceased from 7-18-, 19 40, 7-25-, 19 40;
that I last saw him alive on 7-25-, 19 40;
and that death occurred on the date and hour stated above.

Immediate cause of death
Terminal Pneumonia
(Hypostatic N. M. O.)
Due to _____
Arteriosclerotic Heart Disease.
Due to _____
Other conditions (Include pregnancy within 3 months of death) 9/5/40
PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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? _____ (Specify type of place)
(e) Means of injury !
23. Signature W. M. Crow (M. D. or other)
Address Gen. Hosp # 2 Date signed 7-27

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 Marlowe*

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St.*

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.