

Registration District No. 399

Primary Registration District No. 100

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: K.C. Gen. Hosp.
 (d) Length of stay: In hospital or institution 1 Mo. & 20 days
 In this community Over 16 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 2538 Spruce
 (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Hattie May Bowe
 3. (b) If veteran, name war no
 3. (c) Social Security No. no

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 7th
 year 1941 hour 11 minute 25 A. M.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Frank Payne
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased Sept 22 1865

21. I hereby certify that I attended the deceased from 7-18-41 to Sept. 7th
 that I last saw h. er alive on Sept. 7th, 1941
 and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 11 Days 15
 If less than one day . hr. min.

Immediate cause of death Carcinoma of hepatic duct with Nephrosclerosis

9. Birthplace Michigan

Due to H68

10. Usual occupation at Home

Other conditions H68

11. Industry or business

12. Name Noah Shellhammer
 13. Birthplace no record
 14. Maiden name Savilla Fetter
 15. Birthplace no record

Major findings: See above
 Of operations
 Of autopsy

16. (a) Informant Mrs. Maude C. Howard

(b) Address 2126 Cleveland

17. (a) Removal (b) Date thereof Sept 8-1941
 (c) Place: burial or cremation Conway Springs Kas.

18. (a) Signature of funeral director Mrs. E. N. Foster

(b) Address 918 Brooklyn

19. (a) 9/8/41 (b) M. M. Crow
 (Date received local registrar) (Registrar's signature)

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?
 (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 Dwain K. Thon (M. D. or other)
 Address Med. Dir. K.C. Gen. Hospital Date signed 9-8-41

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

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..... *me*

.....Registered Apprentice No.....

working under my personal supervision.

Signed.....

E. H. [unclear]

Licensed Embalmer No.....

2570

P. O. Address.....

K. O. 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, fact should be so stated above.