

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:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 week**
(Specify whether
In this community **50 years** **0**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL") **3**
(d) Street No. **2000 Summit**
(If rural, give location) **8**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **CHARLES CHOWNING**

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

4. Sex **0** **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **2** **Widowed**
6. (b) Name of husband or wife **Dont know** 6. (c) Age of husband or wife if alive **xx** years
7. Birth date of deceased **July 2 1862**
(Month) (Day) (Year)

8. AGE: Years **79** Months **5** Days **13**
If less than one day hr. min.

9. Birthplace **Platteburg Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**
Pilot Santa Fe R.R.

11. Industry or business
12. Name **Dont know**
13. Birthplace **Dont know**
(City, town, or county) (State or foreign country)
14. Maiden name **Dont know**
15. Birthplace **Dont know**
(City, town, or county) (State or foreign country)

16. (a) Informant **2000 Summit**
(b) Address **I2-18-41**

17. (a) **Burial** (b) Date thereof **Calvary Cemetery**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director **J.F. O'DONNELL CO**
(b) Address **3256 Broadway KC. MO.**

19. (a) **Dec. 16, 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **15**
year **1941** hour **9** minute **30** P. M.

21. I hereby certify that I attended the deceased from **12-8-1941** to **12-15-1941**
that I last saw him alive on **12-15-41** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis - Chronic Progressive**
Due to
Due to

Duration
?
?
?
?

Other conditions (Include pregnancy within 3 months of death)

Major findings: **none** **9 30**
Of operations **yes**
Of autopsy

PHYSICIAN
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) **No**
(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. J. [Signature]** (M. D. or D. O.)
Address **1034 Ridge Bldg** Date signed **12-16-41**

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

MOTHER FATHER

*Dr. J. H. Carter
Qualifying Embalmer*

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, fact should be so stated above.