

FILED AUG 6 1943
 1949

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3202

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 days
 In this community 47 years
 (Specify whether years, months or days)

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. 2019 Kensington
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3. (a) PRINT FULL NAME Maude Cowan

3. (b) If veteran, name war. No. none
 3. (c) Social Security No. none

4. Sex female
 5. Color or race W
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife unknown
 6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased: Oct 14, 1867
 (Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 5
 If less than one day .hr. .min.

9. Birthplace: Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: same

12. Name: R. D. Finigan

13. Birthplace: Indiana
 (City, town, or county) (State or foreign country)

14. Maiden name: Mary Welch
 (City, town, or county) (State or foreign country)

15. Birthplace: Indiana
 (City, town, or county) (State or foreign country)

16. (a) Informant: William Cowan
 (b) Address: 2019 Kensington

17. (a) Place: burial or cremation: Maple Hill Cem. N.
 (b) Date thereof: 7/22/43
 (Month) (Day) (Year)

18. (a) Signature of funeral director: [Signature]
 (b) Address: 2315 [Address]

19. (a) Date received local registrar: 7-22-43
 (b) Registrar's signature: [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
 year 1943 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 10, 1943, to July 19, 1943, that I last saw her alive on July 19, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia
 Circulatory failure

Due to: 109

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations
 Of autopsy

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) Means of injury

23. Signature: [Signature] (M. D. or other)
 Address: _____ Date signed: _____

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

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

JAN 29 1938

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 Ray E Snow
Licensed Embalmer No. 2566
P. O. Address 12C 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.