No. 2
—2-43
5-17-39
X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 4 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37931

State File No.

Registration District No. 154 | Primary Registration District No. 5575 | Registrar's No. 73

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City, Ward 6
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Armour Memorial Home,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution unknown, (Specify whether years, months or days)
In this community unknown, 98 4 x 56

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. Armour Memorial Home,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME William Austin Fowler

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Johnson Fowler

6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased July (Month) 10 (Day) 1865 (Year)

8. AGE: Years 79 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

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

10. Usual occupation at home,

11. Industry or business x

MOTHER FATHER

12. Name Ideon Fowler,
13. Birthplace North Carolina, (City, town, or county) (State or foreign country)
14. Maiden name Mary Bourware,
15. Birthplace Tennessee, (City, town, or county) (State or foreign country)

16. (a) Informant Hannah J. Hall,
(b) Address Armour Home, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-44 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Pantheon

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 11/22/44 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1944 hour 5:50 minute A. M.

21. I hereby certify that I attended the deceased from Sept 10, 1944, to Nov 20, 1944, that I last saw him alive on Nov. 18—, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cancer Prostate,	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23) Signature O W Cantrell (M. D. or other)
Address 636 Argyle (31) Date signed 11/29/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. D. Cantrell

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. 1415

P. O. Address T. C. [illegible]

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.

S. No. 2B
M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Lee

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 73

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cameron Memorial Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm A. Fowler

3. (b) If veteran, name war

3. (c) Social Security No.

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July 10 1866
(Month) (Day) (Year)

8. AGE: Years 72 | Months 4 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

MOTHER FATHER

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1938 hour 3 minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

37931