

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29599
3650

State File No.
Registrar's No.

FILED SEP 20 1945

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8-17-45-9-2-45
(Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 4305 E 15th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cowan, William H.

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

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

6. (b) Name of husband or wife Maudie Cowan
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1-8-1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 7 23 24 hr. min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name Wm. T. Cowan
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Lucinda Yokum
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant David Cowan - Brother
(b) Address Meridan Kans.

17. (a) Kansas City Kans. Date thereof 9-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill Cem.

18. (a) Signature of funeral director _____
(b) Address 4135 E. 15th St. Kansas City, Mo.
19. (a) 9-3-45 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 2nd
year 1945 hour One minute 05 A.M.
21. I hereby certify that I attended the deceased from 8-17-45
to 9-2-45, 19____, to 9-2-45, 19____;
that I last saw h. im alive on 9-2-45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 95C
Major findings: Of operations _____
Of autopsy none
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Charles Seely, M.D.
Address Gen. Hosp. #1 Date signed _____

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

JAN 23 1948

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.....

John B. [Signature]

Licensed Embalmer No. *2935*

P. O. Address *W.C. [Signature]*

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.