7. S. No. 2
00M—5-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36366

FILED NOV 26 1945

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4635

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: General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 mos. 4 days (Specify whether years, months or days)
In this community: 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 4631 E. 7 St. 8
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Mrs. Josie A. Rowan
3. (b) If veteran, name war: xx
3. (c) Social Security No.: None
4. Sex: Fe /
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Perry T. Rowan
6. (c) Age of husband or wife if alive: xx years
7. Birth date of deceased: January (Month) 2 (Day) 1872 (Year)

8. AGE: Years 73 | Months 10 | Days 6 | If less than one day: hr. _____ min.

9. Birthplace: Milwaukee (City, town, or county) Wis. / (State or foreign country)
10. Usual occupation: At Home
11. Industry or business: _____
FATHER 12. Name: Patrick Shelton
13. Birthplace: Ireland 4 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Mary McMahan
15. Birthplace: Ireland 4 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Marie Ryberg
(b) Address: 2219 Poplar
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Mora Cemetery St Joseph Mo.
18. (a) Signature of funeral director: J. W. Wagner
(b) Address: Kansas City, Mo.
19. (a) 11-9-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8 year 1945 hour 8 minute 45 A.M.
21. I hereby certify that I attended the deceased from July 3 1945 to Nov. 8 1945 and that I last saw her alive on Nov. 8 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	
Due to: Fracture of hip	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 1860 5 18	
Major findings: Of operations:	
Of autopsy: See above	

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): Accident
(b) Date of occurrence: 7-3-45 1 2 3
(c) Where did injury occur? K. C. Jackson Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (e) Means of injury: Fall
23. Signature: Clark W. Seal M.D. (M.D. or other)
Address: Med. Dir. Gen'l Hosp. Date signed: 11-8-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

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

working under my personal supervision.

Signed Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.