

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38025**

FILED NOV 24 1947
Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4649**

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: **Wheatley Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**
(Specify whether years, months or days)

In this community **10 days**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~MISSOURI~~ (b) County ~~JACKSON~~ **89**

(c) City or town **Henrietta, Missouri** **0**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. **Box 495**
(If rural, give location) **No**

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **Goldie Bowlin**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **7th**
year **1947** hour **6** minute **10 A** M.

4. Sex **Female** 5. Color or race **Negro**

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

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased: **March 16, 1900**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1947** to **now?** 19**47**
that I last saw **her** alive on **now?** 19**47**
and that death occurred on the date and hour stated above.

Duration **Oct 28**

8. AGE:	Years	Months	Days	If less than one day
	47	7	21hr.min.

Immediate cause of death **Coronary artery atherosclerosis**

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) **40**

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

10. Usual occupation **none**

11. Industry or business.....

12. Name **Unknown**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wheatley Hospital**
(b) Address **H-C-100**

17. (a) **Removal** (b) Date thereof **11/7/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Henrietta, Mo.**

18. (a) Signature of funeral director **Estherine**
(b) Address **1729 Sylvia Ave**

19. (a) **11-7-47** (b) **Alfredine Holmes**
(Date received local registrar) (Registrar's signature)

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? (Specify type of place).....

While at work (e) Means of injury **0**

23. Signature **J. J. [unclear]** (M. D. or other).....
Address **738 1/2 Root** Date signed **11/7/47**

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Signed.....

Registered Apprentice No.....

Licensed Embalmer No. 3944

P. O. Address 2585 Highlap

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.