No. 300
-10-47
-17-39
PI 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 4 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36902

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4581

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

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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution since October, 1948 (Specify whether
In this community as above
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999

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

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

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

If yes, name country X

3. (a) PRINT FULL NAME Charles H. Stowell

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 married

6. (b) Name of husband or wife Mrs. Sophia B. Stowell

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased January (Month) 29 (Day) 1876 (Year)

8. AGE: Years 72 Months 9 Days 6 If less than one day hr. min.

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

10. Usual occupation Farmer and Stockman

11. Industry or business X

FATHER
12. Name Warren Stowell
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sophia B. Stowell
(b) Address Frankfort, Kansas

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-8-48 (Month) (Day) (Year)
(c) Place: burial or cremation Frankfort, Kansas.

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

19. (a) 11-9-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5
year 1948 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 30, 1947, 19__, to Nov. 5, 1948,
that I last saw him alive on Nov 5, 1948,
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	1 mo.
Due to Adeno Carc of Prostate	3 yrs
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?
Wm. A. Staggs (Specify type of place)
While at work? (e) Means of injury

23. Signature Wm. A. Staggs (M. D. or other)
Address 822 Argyle K.C. Mo. Date signed Nov 6 48

(Licensed Embalmer's Statement on Reverse Side)

Dr. W. A. Staggs, Ha 5488
122 Argyle Tu 1:30 to 4 pm

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 Rabur H. Reed

Licensed Embalmer No. 3745

P. O. Address K. C. 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.