

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44350
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5817

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKE'S Hospital</u>		Length of stay in 1b <u>53 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>3624 WALNUT</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM Cecil FOWLER</u>			4. DATE OF DEATH Month Day Year <u>DEC. - 8 - 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14 - 1882</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ADVERTISING</u>	11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN FOWLER</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>GERTRUDE FOWLER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-05-7531</u>	17. INFORMANT Address <u>MRS GERTRUDE FOWLER 3624 WALNUT ST. KANSAS CITY, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mixed Cell Sarcoma of Stomach & extension to Colon, retroperitoneal Area.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months plus</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>retroperitoneal Area.</u>					151X
DUE TO (c)					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bullous Lung Cysts (Emphysematous blebs) Stenosis</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21: I attended the deceased from <u>Nov. 22, 1957</u> to <u>8 Dec. 1957</u> and last saw her alive on <u>7 Dec. 1957</u> Death occurred at <u>6:10 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Philip G. Kaul MD.</u>			22b. ADDRESS <u>411 Nichols Rd.</u>		22c. DATE SIGNED <u>12-8-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC. 10 - 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CREEK RANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>12-10-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Philip G. Kaul

42
20

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Chester K Brown*

Licensed Embalmer No. *493*
P. O. Address *K O M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.