

FILED JUL 30 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025765  
STATE FILE NUMBER

5520 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3425

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5914 Walrond</b>	
Length of stay in lb <b>14 hours</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Infant</b> Middle <b>Rowe</b> Last <b>Rowe</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1958</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1958</b>	9. AGE (In years last birthday) <b>14</b>	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>	IF UNDER 24 HRS. Hours <b>14</b> Min. <b>14</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>George W. Rowe</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Lou Alexander</b>	14. NAME OF HUSBAND OR WIFE <b>--</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mary Lou Rowe</b> Address <b>5914 Walrond K. C. Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>volvulus of small intestine</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) **operation 5-8-58- volvulus & peritonitis**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)  
**acute fibrinous peritonitis**

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____
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20d. INJURY OCCURRED WHILE AT WORK <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 <b>Kansas City</b> COUNTY <b>Jackson</b> STATE <b>Missouri</b>
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21. I attended the deceased from <b>5-8-58</b> to <b>5-8-58</b> and last saw her/him alive on <b>5-8-58</b> Death occurred at <b>11:45P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Name or title) <b>Raymond B Anderson MD</b>	22b. ADDRESS <b>411 Nichols Rd. K. C. Mo.</b>	22c. DATE SIGNED <b>5-9-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	23b. DATE <b>5-15-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Hospital</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Nelson E. Powell</b> ADDRESS <b>M. D. St. Luke's Hosp.</b>	25. DATE RECD. BY LOCAL REG. <b>7-14-58</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>
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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.

Raymond B. Anderson, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



STATEMENT BY ~~LICENSED EMBALMER~~ *Physician*

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~

~~by me~~ *cremated* ..... Student Embalmer No. ~~.....~~

~~working~~ under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Nelson E. Powell, M.D.*  
*St. Luke's Hosp., K.C. Mo.*  
Licensed Embalmer No. ....

P. O. Address .....

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.