

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043990
STATE FILE NUMBER
5803

WED DEC 30 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5803

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Lexington	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital		d. STREET ADDRESS (If outside, give location) 2205 Aull Lane	
3. NAME OF DECEASED (Type or print) First John Middle Arthur Last Bowers		4. DATE OF DEATH Month Dec. Day 8, Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping & Receiving clerkment. Co.		10b. KIND OF BUSINESS OR INDUSTRY Shipping & Receiving Co.	11. BIRTHPLACE (City and state or country) Lexington Mo.
13a. FATHER'S NAME Frank J. Bowers		13b. MOTHER'S MAIDEN NAME Mary Elizabeth Hare	14. NAME OF HUSBAND OR WIFE Thomas F. Bowers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W. W. #2		16. SOCIAL SECURITY NO. 495-10-4410	17. INFORMANT Thomas F. Bowers Address Lexington Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & hemorrhage secondary to fractured skull		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Skull fracture secondary to hemorrhage & crushing injury of chest			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) Fell from 20 story high		
20c. TIME OF INJURY 8:05 a.m. - 12-8-58	20f. CITY, TOWN, OR LOCATION Lexington COUNTY Jackson STATE Mo.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		
21. I attended the deceased from _____, to _____, and last saw him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Geo. C. Kealhofer (Degree or title) 3		22b. ADDRESS 6627 Woodfield Lane	22c. DATE SIGNED 12-8-58
23a. BURIAL, CREMATION, REMOVAL Removal	23b. DATE 12/8/58	23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (City, town, or county) (State) Lexington Mo.
24. FUNERAL DIRECTOR Stine & McClure ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 12-9-58	26. REGISTRAR'S SIGNATURE neva minahall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 6 1959

JAN 2 1959

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 *Eugene T. Korman*

Licensed Embalmer No. *4633*
P. O. Address *R. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

DEC 30 1958