

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044423
STATE FILE NUMBER
5707

47504-58
FILED DEC 18 1958
8035

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

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	54% CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hosp.		Length of stay in 1b 6 mo 15 da	d. STREET ADDRESS (If outside, give location) 1915 E. 34th. St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First David Middle Keith Last Stowers			4. DATE OF DEATH November 29, 1958 Month November Day 29 Year 1958		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1958	9. AGE (In years last birthday) 24 2 1/2 IF UNDER 1 YEAR: Months 24 Days 2 Hours 1/2 IF UNDER 24 HRS.: Hours 1/2 Min.
--------------------	-------------------------------	---	--------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	---

13a. FATHER'S NAME Joseph Stowers	13b. MOTHER'S MAIDEN NAME Betty Stowers Melton	14. NAME OF HUSBAND OR WIFE -----
---	--	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. -----	17. INFORMANT Betty Stowers Address 1915 E. 34th. St.
--	----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 48 hours -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		491X

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.)
---	--

20c. TIME OF INJURY Hour _____ .Month, Day, Year a.m. _____ p.m. _____	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Kansas City COUNTY _____ STATE _____
---	--	---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION Kansas City COUNTY _____ STATE _____
---	---

21. I attended the deceased from **11-28-58** to **11-29-58** and last saw him alive on **11-29-58**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. P. McCalla, M.D.	22b. ADDRESS 2610 E 63rd.	22c. DATE SIGNED 12-1-58
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/2/58	23c. NAME OF CEMETERY OR CREMATORY Green Lawn	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR Stine & McClure ADDRESS K. C. Mo.	25. DATE RECD. BY LOCAL REG. 12-2-58	26. REGISTRAR'S SIGNATURE Neva Marshall
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

J. P. Mc Calla



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 L. ...*

Licensed Embalmer No. *4633*

P. O. Address *E. C. 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.