

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4486 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>JOHNSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>KANSAS CITY</b>		Length of stay in 1b <b>7 yrs.</b>	c. CITY OR TOWN <b>PRAIRIE HILLS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3660 SUMMIT ST. ROANOKE NURSING HOME</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3512 W. 71st STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>ROSALIE COWAN</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>14</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8 4 67</b>	9. AGE (last birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>BADEN, SWITZERLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>UNKNOWN BOLLAG</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>JOSEPH A COWAN</b>	
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>MORT G. COWAN 3512 W. 71st STREET</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>			<b>2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CONGESTIVE HEART FAILURE</b>		<b>2 DAYS</b>
	DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>20 YRS.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	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	COUNTY STATE

21. I attended the deceased from 1957 to SEPT. 14, 1959 and last saw her alive on SEPT. 14, 1959  
 Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In free or type) <b>George K. Landis, M.D.</b>	22b. ADDRESS <b>1630 Professional Bldg</b>	22c. DATE SIGNED <b>9/14/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>SEPT 23, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D. W. NEWCOMER'S SONS</b>
23d. LOCATION (City, town, or county) <b>KANSAS CITY, MO.</b>		24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS K. C. MO.</b>
25. DATE RECD. BY LOCAL REG. <b>9-15-59</b>		26. REGISTRAR'S SIGNATURE <b>neva munnahall</b>

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
Geo. K. Landis

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Chester K. Bruce

Licensed Embalmer No. 492

P. O. Address K.P. 10

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.