

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032343

FILED VS. SEP 23 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4249

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 8 days		c. CITY OR TOWN Kansas-City Westwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2929 West 49th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILLARD Middle M. Last FOWLER				4. DATE OF DEATH Month August Day 30 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-15-1907	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-westport Printing		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (City and state or country) Nebraska City, Nebr.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles E. Fowler			13b. MOTHER'S MAIDEN NAME Daisy Alexander		14. NAME OF HUSBAND OR WIFE Gladys B. Fowler		
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. 488-38-5620		17. INFORMANT Address Mrs. Gladys B. Fowler, 2929 W. 49th			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy						INTERVAL BETWEEN ONSET AND DEATH 8 wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) ? periarthritis nodosa						8 wks	
DUE TO (c)							
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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.		Month, Day, Year					
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 Dec 1 - 59 , to Aug 30 - 59 and last saw him alive on Aug 30 - 59 Death occurred at 3:00 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Revis C Lewis M.D.				22b. ADDRESS 411 Nichol, Rd Kansas City, Mo		22c. DATE SIGNED Aug 31 - 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		23d. LOCATION (City, town, or county) Kansas City, Missouri		(State)	
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 9-1-59		26. REGISTRAR'S SIGNATURE Neva Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Revis C. Lewis**

Dr. R. B. Fowler
411 Buchanan
JE 1-1643
2-59' clock
OK

FOWLER-OK

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 Walter H. Erwin

Licensed Embalmer No. 4352
P. O. Address K. E. 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.