

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2823 STATE FILE NUMBER

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) Kansas City		Length of stay in 1b 40yrs	c. 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) Albrittan Nurseing Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2314 Vine Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mable Middle Bowers Last Bowers			4. DATE OF DEATH Month 5 Day 20 Year 60		
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5. SEX Fe	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Unknown	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jacob Bowers
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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) NO	16. SOCIAL SECURITY NO. -	17. INFORMANT J D Williams 2331 Vine	Address
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18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mo
DUE TO (b) Arteriosclerosis		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) atrial fibrillation		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 type="checkbox"/> NO <input checked="" 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.) none
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20c. TIME OF INJURY none	20d. INJURY OCCURRED WHILE AT WORK (Specify) none	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) none	20f. CITY, TOWN, OR LOCATION Kansas City Jackson, Mo
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21. I attended the deceased from Feb 13, 60 to 20 Feb 60 and last saw her alive 7/20 Feb 60	
Death occurred at 11:37 AM on the date stated above, and to the best of my knowledge, from the causes stated.	

22. SIGNATURE (Deceased or title) John H Wells MD	22b. ADDRESS 4011 Linwood Blvd	22c. DATE SIGNED 23 May 60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-24-60	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
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24. FUNERAL DIRECTOR Manlove-Williams 1729 Lydia	25. DATE RECD. BY LOCAL REG. 5-24-60	26. REGISTRAR'S SIGNATURE Reva Marshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John H. Wells

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 _____

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.