

NOV 12 1945

1002

Registrar's No. 3865

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME EDWARD OWENS

3. (b) If veteran, name war no 3. (c) Social Security 419-03-0739

4. Sex male 5. Color of race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 23, 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 12 If less than one day hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Hiram Owens

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hunsbman

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Grover Owens

(b) Address North K. C. Mo.

17. (a) Burial (b) Date thereof 10-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty, Missouri

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North K. C. Mo.

19. (a) 10-6-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit: write "RURAL")
(d) Street No. 3725 Montgall
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5th
year 1940 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from 9-28-40, 19____, to 10-5-40, 19____;

that I last saw him alive on 10-5-40, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Subacute coronary occlusion; Diffuse Myocardial fibrosis

Due to _____
Due to _____

Other conditions Pulmonary Embolism
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy See above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. M. Brown (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

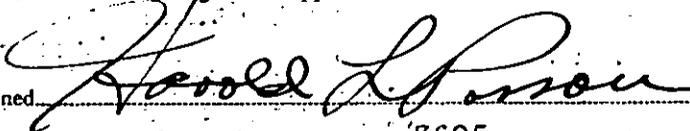
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Harold L. Posson

working under my personal supervision.

Registered Apprentice No.

Signed



Licensed Embalmer No. 3605

P. O. Address North K. 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 this body is not embalmed, above space should be left blank.