

FILED JAN 31 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

559

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>59</u>		PRIMARY REG. DIST. NO. <u>4105</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH a. COUNTY <u>CASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>CASS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PECULIAR</u>		c. LENGTH OF STAY (in this place) <u>1 1/2</u> YEARS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PECULIAR</u>		19 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MAIN street</u>				d. STREET ADDRESS (If rural, give location) <u>MAIN Street</u>			
3. NAME OF DECEASED (Type or Print) <u>LESLIE</u>		a. (First)		b. (Middle) <u>CLEO</u>		c. (Last) <u>OWEN</u>	
4. DATE OF DEATH		(Month) <u>JAN.</u>		(Day) <u>23,</u>		(Year) <u>1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MARCH 17, 1905</u>	
9. AGE (In years last birthday) <u>43</u>		IF UNDER 1 YEAR		MONTHS <u>10</u>		DAYS <u>7</u>	
IF UNDER 24 HRS. Hours <u>0</u>		Mins. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>CLINTON, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FILLING STATION</u>				
13a. FATHER'S NAME <u>WILLIAM OWEN</u>			13b. MOTHER'S MAIDEN NAME <u>LULA POLAND</u>			14. NAME OF HUSBAND OR WIFE <u>PEARL OWEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. LESLIE C. OWEN</u>		ADDRESS <u>PECULIAR, MO</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>AORTIC REGURGATION</u>		INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES		DUE TO (b) <u>ENLARGED HEART</u>					
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>PULMONARY OEDEMA</u>					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>OVER EXERTION</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>5</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-12</u> <u>1947</u> to <u>1-23</u> <u>1949</u> , that I last saw the deceased alive on <u>1-23</u> <u>1949</u> , and that death occurred at <u>4:55</u> <u>P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James H. Long M.D.</u>				23b. ADDRESS <u>Harrisonville Mo</u>		23c. DATE SIGNED <u>1-25-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN. 25 '49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Peculiar Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Peculiar Mo</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 25-1949</u>		REGISTRAR'S SIGNATURE <u>Laura J. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. R. George &amp; Sons</u>		ADDRESS <u>BELTON, Mo.</u>	

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

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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.

Signed..... *A. K. Seamp* .....

Signed.....  
Student Embalmer

Licensed Embalmer No. *3645* .....

P. O. Address *Grandview, 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, fact should be so stated above.