

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25068

State File No. \_\_\_\_\_

FILED JUL 17 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3261</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>70 YEARS</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>Cresthaven Nursing Home</u>				e. STREET ADDRESS (If rural, give location) <u>421 NORTH GLADSTONE BLVD</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LAVINIA</u>			b. (Middle) <u>GRACE</u>		c. (Last) <u>OWEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 24, 1953</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCT-5-1860</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY .....		11. BIRTHPLACE (City and State or Foreign Country) <u>ONTANOGAN MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOHN WILLIAMS</u>			13b. MOTHER'S MAIDEN NAME <u>LAVINIA TREMAIN</u>		14. NAME OF HUSBAND OR WIFE <u>RICHARD HARGRAVE OWEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. ANNIE LEE PARRY 421 N. GLADSTONE BLVD</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Laceration of right eye</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  1921					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>3516 Summit St</u>		21c. (CITY, TOWN, OR TOWNSHIP) COUNTY STATE <u>K.C. Jackson Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>June 19, 1953</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>fall off stool</u>			
22. I hereby certify that I attended the deceased from <u>June 24, 1953</u> , to <u>June 24, 1953</u> , that I last saw the deceased alive on <u>June 24, 1953</u> , and that death occurred at <u>9:00 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Full name of physician) <u>Allen C. Carbaugh MD</u>				23b. ADDRESS <u>2004 Bryant Blvd KC Mo</u>		23c. DATE SIGNED <u>6-25-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 27 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>6-27-53</u>		REGISTRAR'S SIGNATURE <u>Thereldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE (Address) <u>Outlookers Sons Kansas City Mo</u>			

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

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AUG 10 1950

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 *Edward M. Stone*.....

Licensed Embalmer No. *442*

P. O. Address *K.C. 101*

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.