

t. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
1422

FILED APR 25 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 300  
V. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Hugh H. Owens

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>316 Oak</b>		Length of stay in 1b <b>50 Years</b>	d. STREET ADDRESS (If outside, give location) <b>3536 Highland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Park</b> Last <b>Ford</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>♂</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 11 1893</b>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schlitz Brewery</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>George Park Ford</b>		13b. MOTHER'S MAIDEN NAME <b>Lillian Reece</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs Bessie Mae Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>BS W. W. I</b>		16. SOCIAL SECURITY NO. <b>486-10-3225</b>		17. INFORMANT Address <b>Bessie Mae Ford 3536 Highland Kan City, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, aortic aneurysm ruptured</b> DUE TO (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>451 X</b>	
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 _____ Month, Day, Year _____ a.m. _____ p.m.					
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 _____, to _____ and last saw her alive on _____ ✓ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Hugh H. Owens, M.D.</b>			22b. ADDRESS <b>1034 Pichler Bldg</b>		22c. DATE SIGNED <b>3-27-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B. burial</b>		23b. DATE <b>3-28-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Washington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Melody McGilley Lylar Kan City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>3-27-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

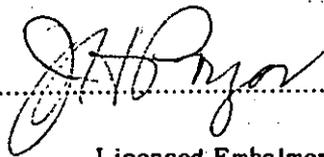
2-28/3

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. 2999

P. O. Address K. E. Me

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.