

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 446

1. Health,
& Welfare
5. Public
Health Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Prairie Hill</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>H. of M. Medical</u> | | Length of stay in lb <u>45 days</u> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Essie</u> Middle <u>Jay</u> Last <u>Owens</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1957</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>3/27/88</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural Mail Carrier</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | 9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 11. BIRTHPLACE (City and state or country) <u>Chariton Co. Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John M. Hurt</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Yocum</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>488-18-5114</u> | 17. INFORMANT <u>Patients' Hospital chart.</u> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Ovary & Metastases.</u> 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 <u>2 Months</u> <u>11 Months</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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.) <u>175X</u> | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____ | | 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 <u>10/20/57</u> to <u>12/4/57</u> and last saw her him alive on <u>12/4/57</u> Death occurred at <u>10:25 Pm.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>H. M. Williams Jr. M.D.</u> | | 22b. ADDRESS <u>46 Univ. Hosp Columbia, Mo.</u> | 22c. DATE SIGNED <u>12/4/57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>12/5-1957</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) <u>Moberly Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Million Funeral Home, Moberly, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Dec 5 1957</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u> |

William S. Hasse
Waverly, Mo

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.....
Richard S. Doyne

Licensed Embalmer No. *4958*

P. O. Address *Moberly*

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..