

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010089

STATE FILE NUMBER

1425

FILED APR 2 1958

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. (If Institution, Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <i>Jones City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Jackson</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>209 Washington</i>		Length of stay in lb <i>8 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>709 Washington</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>P.</i> Last <i>Minnick</i>			4. DATE OF DEATH Month <i>3</i> Day <i>14</i> Year <i>58</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-5-1893</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pharmacist</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years (last birthday)) <i>64</i> IF UNDER 1 YEAR: Months <i>6</i> Days <i>27</i> IF UNDER 24 HRS.: Hours <i>6</i> Min. <i>0</i>
11. BIRTHPLACE (City and state or country) <i>Fallston Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <i>Rock Springs Mo</i> OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, give year or years of service) <i>Yes World War I</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Vet Adm</i> Address <i>R.C. Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4:00</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Astoria from Vets Hosp</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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/him 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) <i>Hugh H Owens</i>		22b. ADDRESS <i>1034 Purity Bldg</i>	22c. DATE SIGNED <i>3-17-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>Mar. 19, 58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>U.S. Natl. Cem</i>	23d. LOCATION (City, town, or county) (State) <i>Hopevenworth Mo</i>
24. FUNERAL DIRECTOR <i>Don B Logelma</i>	ADDRESS <i>R.C. Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>3-18-58</i>	26. REGISTRAR'S SIGNATURE <i>reva minshall</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

All diseases in Part I must be causally related.

Health, Welfare, Public Service

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APR 9 1958

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 *Robert B. [Signature]*

Licensed Embalmer No. 4273  
P. O. Address 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.