

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004524  
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 10

300

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1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Centralia		c. CITY OR TOWN Columbia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hulen Nursing Home		d. STREET ADDRESS (If outside, give location) 214 Texas Ave.	
3. NAME OF DECEASED (Type or print) ROBERT WILSON OWENS		4. DATE OF DEATH March 7, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (City and state or country) Monticello, Arkansas
13a. FATHER'S NAME Milton Owens		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Laura Alice Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Hughes L. Buerger Jr. 214 Texas Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchial pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral artery thromboses, Multiple DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs Also present Year
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 10/10/58 to 2/4/59 and last saw her/him alive on 2/4/59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John L. Ward MD		22b. ADDRESS 120 N. Rollins, Centralia, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-7-1959	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Monticello, Arkansas	
24. FUNERAL DIRECTOR Parker Funeral Service, Columbia, Mo.		25. DATE RECD. BY LOCAL REG. March 7, 1959	
26. REGISTRAR'S SIGNATURE Maud Mc Bride			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Tom M. Harg .....

Licensed Embalmer No. 4067 .....

P. O. Address Columbia .....

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.