Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004609
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 182

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph Hosp. — Length of stay in 1b 20yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph, 0117 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1913 So 13th — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Leona Middle: Mae Last: Owens

4. DATE OF DEATH Month Day Year: Feb 13, 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: April 21, 1921
9. AGE (In years last birthday): 37 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Bloomington Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: ? Thomas
13b. MOTHER'S MAIDEN NAME: Rosa Cameron
14. NAME OF HUSBAND OR WIFE: Earl Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Earl Owens Address: St. Joseph, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Glioblastoma brain — INTERVAL BETWEEN ONSET AND DEATH: 6 months
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): 1930
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Jan. 30, 1959, to Feb 13, 1959 and last saw him alive on Feb. 13, 1959
Death occurred at 3:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

22a. SIGNATURE Allen I Herman (Degree or title) M.D.
22b. ADDRESS 706 Francis St. Joseph, Mo.
22c. DATE SIGNED 2-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/16/59
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo

24. FUNERAL DIRECTOR John C. Rupp ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. Feb. 19 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

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 ..... John E. Rush

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.