

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959 149

59-029249

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4071 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson													
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 3 1/2 YRS.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hosp. #1			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3604 Wyandotte		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Neal Keith Owen				4. DATE OF DEATH Month Aug. Day 18, Year 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 MA 26, 1931		9. AGE (last birthday) 28		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Kansas City Fire Dept.				11. BIRTHPLACE (City and state or country) WAYNE CO. IOWA		12. CITIZEN OF WHAT COUNTRY USA							
13a. FATHER'S NAME Delbert Owen				13b. MOTHER'S MAIDEN NAME GLADYS MC MURRY				14. NAME OF HUSBAND OR WIFE Emma Owen									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1951-1954				16. SOCIAL SECURITY NO. 481 30 1388		17. INFORMANT Address EMMA OWEN 3604 WYANDOTTE K. C. MO.											
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>Shock</u> DUE TO (b) <u>Secured & kind of gas burns</u> DUE TO (c) <u>over entire body</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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>While fighting fire, explosion</u>													
20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. <u>8-18-59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City Jackson Mo.</u>		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 <u>Geo. Kealhofer</u> (Degree or title)						22b. ADDRESS <u>6627 Proberts Ave</u>				22c. DATE SIGNED <u>8-19-59</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE AUG 21, 1959		23c. NAME OF CEMETERY OR CREMATORY ALLERTON IOWA CEM				23d. LOCATION (City, town, or county) (State) ALLERTON IOWA.									
24. FUNERAL DIRECTOR D.W. Newcomers Sons Kansas City, Mo.						25. DATE RECD. BY LOCAL REG. 8-21-59		26. REGISTRAR'S SIGNATURE <u>Neva Minchall</u>									

DOCUMENT

BY AFFIDAVIT OF Geo. Kealhofer MEDICAL CERTIFICATION

SEP 4 1969

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Vern Lawler

Licensed Embalmer No. 4915

P. O. Address H.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.