DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 7 1960 Registration District No. 195 Primary Registration District No. _____ Registrar's No. 70-60 -60-031277 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY: McDonald	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo b. COUNTY: McDonald
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Anderson — Length of stay in 1b: 10 YR	c. CITY OR TOWN: Anderson — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): RT 1 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Samuel Middle Vance Last Owens

4. DATE OF DEATH: Month 8 Day 28 Year 1960

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
M	W		1-27-1889	71	7	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Laborer	Ret.	Stotts City Mo	U.S

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
John T Owens	Sarah Gatton	—

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	No	None	Jim Owens	Anderson 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): Cerebral Anoxia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Acute Viral Pneumonia

DUE TO (c):

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 8-25-60, to 8-28-60 and last saw him alive on 8-28-60

Death occurred at 1:30 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
W White M.D.	Pineville, Mo.	8-31-60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	8-30-60	Anderson Cem	Anderson Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Humphrey & Son F Home	M. H.	Sept. 1, 1960	Mary A. Bradley

(Licensed Embalmer's Statement on Reverse Side) Ref. 22A W.F. STILES, D.O.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Maynard E Stump

Signature of Student Embalmer

Licensed Embalmer No. 42662

P. O. Address Fairmont

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.