

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017940

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 277

FILED MAY 31 1961

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> | | Length of stay in lb <u>10 years</u> | | c. CITY OR TOWN <u>Independence</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2113 Spring</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2113 Spring</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Owens</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1961</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Cauc.</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN. 20, 1905</u> | | |
| 9. AGE (last birthday) <u>56</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> | | 11. BIRTHPLACE (City and state or country) <u>Pierce Town ARK.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Owens</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Nancy Pierce</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Sally Owens</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT <u>Salley Owens</u> Address <u>2113 Spring</u> | | |
| 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>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis (possible)</u> DUE TO (c) _____ 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 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u> <u>Unknown</u> | |
| 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. Month, Day, Year _____ | | 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 <u>Aug 4, 1958</u> to <u>May 21, 1961</u> and last saw him alive on <u>May 24, 1961</u> Death occurred at <u>May 24, 1961 11:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>B H Boyd & J. D. D.</u> | | | | 22b. ADDRESS <u>9529 Juniper Road</u> | | 22c. DATE SIGNED <u>5/25/61</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>MAY 27, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Memory Garden</u> | | 23d. LOCATION (City, town, or county) (State) <u>Ray Town, Missouri</u> | | |
| 24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 TRUST</u> | | | | 25. DATE REGD. BY LOCAL REG. <u>5-27-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u> | | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

JUN 2 1961

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 *R. E. Nichols*

Licensed Embalmer No. 4997

P. O. Address R. P. M.

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.

897