

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045629

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 86

AMENDED

FILED JAN 2 1962	
1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>	c. CITY OR TOWN <b>Charleston</b>
Length of stay in 1b <b>10 days</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt. 2, Box 19</b>	d. STREET ADDRESS (If outside, give location) <b>Rt. 2, Box 19</b>
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Clementine Clemon T. Owens</b>			4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/61</b>	9. AGE (last birthday) -----	IF UNDER 1 YEAR Months <b>10</b> Hours <b>10</b> Min.
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) <b>Charleston, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Edgar Owens</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Clemmons</b>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Edgar Owens, Rt. 2, Box 19, Charleston, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Bi-latear<sup>A</sup>l Lobar Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
IMMEDIATE CAUSE (a)  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)		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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year	
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **12/9/61** to **12/19/61** and last saw <sup>her</sup> him alive on **(her) 12/9/61**  
Death occurred at **11:00 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John L. Sample, M.D.</b> (Degree or title)		22b. ADDRESS <b>204 Locust Charleston, Mo.</b>	22c. DATE SIGNED <b>12/21/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 20, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>
24. FUNERAL DIRECTOR <b>L. P. Sparks</b> Charleston, Missouri		25. DATE RECD. BY LOCAL REG. <b>12-20-61</b>	26. REGISTRAR'S SIGNATURE <b>Donatly B. Hacklorn</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

JAN 2 1962

**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.

This body was not embalmed.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Louis Robert Jones

Licensed Embalmer No. 5132

P. O. Address Charleston

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.