MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-001928
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 28

FILED JAN 18 1962

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 20 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: General Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1109 E 9th
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: La Vern Middle: none Last: Owens

4. DATE OF DEATH: Month 1 Day 1 Year 62

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-17-1911
9. AGE (last birthday): 50
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): retired Proprietor
10b. KIND OF BUSINESS OR INDUSTRY: Auto-Tow Service
11. BIRTHPLACE (City and state or country): Blythedale, Ark.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Millard Owens
13b. MOTHER'S MAIDEN NAME: Alta Russell
14. NAME OF HUSBAND OR WIFE: Roberta 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.: –
17. INFORMANT: Roberta Owens, Address: Kansas City, 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) Acute hemorrhage from esophageal varices
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
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 12-26-61, to 1-1-62 and last saw him alive on 1-1-62
Death occurred at 12:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. Frank Ellis MD
22b. ADDRESS: 3400 Cherry
22c. DATE SIGNED: 1-2-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-3-62
23c. NAME OF CEMETERY OR CREMATORY: –
23d. LOCATION (City, town, or county) (State): Eagleville Mo.

24. FUNERAL DIRECTOR: Burgess Mortuary, ADDRESS: Eagleville Mo
25. DATE RECD. BY LOCAL REG.: 1-4-62
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

AMENDED

TYPEWRITER RIBBON

RITE TUB

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_____ Signed John R. Simon
Signature of Student Embalmer

Licensed Embalmer No. 4531

P. O. Address Kansas City, 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.