

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016965

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 231 Primary Registration District No. _____ Registrar's No. 115

FILED MAY 13 1963

VS 300
Rev. 4/59

1 0740

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Elmo</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>Skidmore</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Marks Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>REBECCA MINERVA OWENS</u>			4. DATE OF DEATH <u>5-1-1963</u>
5a. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME-OWN</u>	9. AGE (last birthday) <u>80</u>
11a. FATHER'S NAME <u>HENRY ORICK</u>		11b. MOTHER'S MAIDEN NAME <u>SARAH YEARY</u>	11c. NAME OF HUSBAND OR WIFE <u>J.C. OWENS</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or for unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO. <u>762B-REED OWENS-MARYVILLE Mo</u>	17. INFORMANT <u>REED OWENS-MARYVILLE Mo</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>CONGESTIVE HEART FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ACUTE HEMOLYTIC ANEMIA</u>			<u>6 months</u>
DUE TO (c) <u>ADVANCED HODGKINS DISEASE</u>			<u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>UNCONTROLLED DIABETIS; SENILITY</u>			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 _____ a.m. _____ 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 <u>April 29-63</u> to <u>May 1, 1963</u> and last saw her <u>her</u> alive on <u>Apr. 30-1963</u> Death occurred at <u>1:00</u> <u>A</u> - m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Alfred D. Muselman, M.D.</u>		22b. ADDRESS <u>Box 388 Clearmont, Mo.</u>	22c. DATE SIGNED <u>5-7-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-3-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem - Skidmore Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Skidmore Mo.</u>
24. FUNERAL DIRECTOR <u>Atchison-Maryville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-7-63</u>	26. REGISTRAR'S SIGNATURE <u>Deo Fall</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

E. M. Altusaw

Licensed Embalmer No. 2279

P. O. Address

Maryville, 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.