

FILED JAN 21 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5318

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Kansas City Osteopathic Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hrs
(Specify whether in this community years, months or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 330 No Topping 8
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No) ()
If yes, name country _____

3. (a) PRINT FULL NAME John M. Owens

3. (b) If veteran name war No

3. (c) Social Security No. 480-16-3496

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20
year 1945 hour 6 minute 25 A.M.

21. I hereby certify that I attended the deceased from July 23 1945 to Dec 20 1945
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Mar. 3

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: 2 8-1879
(Month) (Day) (Year)

Immediate cause of death: Decompensated myocarditis 1 yr.
Due to Essential Hypertension 3 yrs.

8. AGE: Years Months Days If less than one day

66 10 78 12 hr. min.

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

9. Birthplace: Soldier Kansas
(City, town, or county) (State or foreign country)

Major findings: ASC

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation: Farmer

11. Industry or business: Self

12. Name: Herbert Owens

13. Birthplace: Pa. 1
(City, town, or county) (State or foreign country)

14. Maiden name: Nancy Morrison

15. Birthplace: Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant: Clarence Owens

(b) Address: 330 No Topping

17. (a) Burial (b) Date thereof: 12-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Liberty Mo.

18. (a) Signature of funeral director: John P. Sheel

(b) Address: Kansas City Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

19. (a) 12-24-45 (b) E. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury: 2

Signature: J. J. Fossik (M. D. or other) DO.

Address: 5902 St. John Date signed: 12/28/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
100366

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed John P. Sheil
Licensed Embalmer No. 3625
P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.