

FILED APR 4 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8086

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 272-A

|                                                                                                                                                                                                                                                           |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene Co.</u>                                                                                                                                                                                                          |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Dallas Co.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                              |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield, Mo.</u>                                                                                                                                                      |                           | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Buffalo Mo.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| c. LENGTH OF STAY (In this place) <u>5 days</u>                                                                                                                                                                                                           |                           | d. STREET ADDRESS (If rural, give location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                              |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hosp.</u>                                                                                                                                                                                            |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Lucile</u> b. (Middle) <u>Daisy</u> c. (Last) <u>Owensby</u>                                                                                                                                         |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. DATE OF DEATH (Month) (Day) (Year) <u>Mar-23-1949</u>                     |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                           | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 8. DATE OF BIRTH <u>Feb 14-1919</u>                                          |
| 9. AGE (In years last birthday) <u>30</u>                                                                                                                                                                                                                 |                           | 10. MONTHS <u>1</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. DAYS <u>9</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>Housewife</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 11. BIRTHPLACE (State or foreign country) <u>Dallas Co. U Mo.</u>            |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>                                                                                                                                                                                                                 |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| 13a. FATHER'S NAME <u>Charley Walker</u>                                                                                                                                                                                                                  |                           | 13b. MOTHER'S MAIDEN NAME <u>Iva Adams</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. NAME OF HUSBAND OR WIFE <u>Don W Owensby</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. <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Don W. Owensby Buffalo, Mo.</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                            |                           | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pregnancy</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Partial Intestinal Obstruction</u> <u>4 days</u><br>DUE TO (c) <u>Bronchial Pneumonia</u> <u>2 days</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>1/1/49</u><br><u>6483</u> |                                                                              |
| 19a. DATE OF OPERATION <u>3-21-49</u>                                                                                                                                                                                                                     |                           | 19b. MAJOR FINDINGS OF OPERATION <u>Cesarean section + released adhesions causing obstruction</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                              |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)                                                                                                                                                                                                                  |                           | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                              |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.                                                                                                                                                                                                        |                           | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21f. HOW DID INJURY OCCUR <input checked="" type="checkbox"/>                |
| 22. I hereby certify that I attended the deceased from <u>2-20, 1949</u> , to <u>3-23, 1949</u> , that I last saw the deceased alive on <u>4-23, 1949</u> , and that death occurred at <u>10:25 p. m.</u> , from the causes and on the date stated above. |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| 23a. SIGNATURE (Degree or title) <u>J. L. Johnston M.D.</u>                                                                                                                                                                                               |                           | 23b. ADDRESS <u>Springfield, Mo.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 23c. DATE SIGNED <u>3-25-49</u>                                              |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                   |                           | 24b. DATE <u>3-27-49</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>                           |
| 24d. LOCATION (City, town, or county) (State) <u>Buffalo, Mo.</u>                                                                                                                                                                                         |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| DATE REC'D BY LOCAL REG. <u>4/2/49</u>                                                                                                                                                                                                                    |                           | REGISTRAR'S SIGNATURE <u>W. S. Haudley M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                              |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Montgomery-Vaughan</u>                                                                                                                                                                                                |                           | ADDRESS <u>Buffalo, Mo.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                              |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Signed Blyde Montgomery  
Licensed Embalmer No. 3592

Signed.....  
Student Embalmer

P. O. Address Buffalo, 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.