

REC'D JUL 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44345**

BIRTH NO. _____ REG. DIST. NO. **373** PRIMARY REG. DIST. NO. **6269** Registrar's No. **38**

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARSHFIELD MO - 12 mile		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - 12 mile	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION WEBSTER CO HOME			

3. NAME OF DECEASED (Type or Print) GEORGE OWENS	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12-27-57
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5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 2-22-1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 5	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	10b. KIND OF BUSINESS OR INDUSTRY LABOR	11. BIRTHPLACE (State or foreign country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME MARK OWENS	13b. MOTHER'S MAIDEN NAME ELIZABETH LOVELL	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ALFORD OWENS	ADDRESS SEYMOUR MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION*		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Deplete Febrile		
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Primum febr DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) no
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-1-57**, 1957, to **12-27**, 1957, that I last saw the deceased alive on **12-7**, 1957, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W F Schmidt M.D.	23b. ADDRESS Wingard MO	23c. DATE SIGNED 1-23-58
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-20-57	24c. NAME OF CEMETERY OR CREMATORY GENTRY	24d. LOCATION (City, town, or county) (State) WEBSTER CO. MO
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DATE REC'D BY LOCAL REG. 1-1-58	REGISTRAR'S SIGNATURE J. H. ...	25. FUNERAL DIRECTOR'S SIGNATURE Kelly J. ...	ADDRESS Bergman Seymour MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1120
510

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
Student Embalmer

Signed K K Kelley

Licensed Embalmer No. 3934

P. O. Address Fordland 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.