

FILED MAY 25 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDR. FERRELL PARK
State File No. 17713

BIRTH NO. _____		REG. DIST. NO. <u>128</u>	PRIMARY REG. DIST. NO. <u>2000</u>	Registrar's No. <u>477</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MOUNTAIN VIEW</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>MORGAN</u>		a. (First) _____	b. (Middle) _____	c. (Last) <u>OWENS</u>	
4. DATE OF DEATH <u>MAY 18, 1953</u>		5. SEX <u>MALE</u>			
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>			
8. DATE OF BIRTH <u>Oct. 31, 1886</u>		9. AGE (In years last birthday) <u>66</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Cobalt Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert P. Owens</u>			
13b. MOTHER'S MAIDEN NAME <u>ALICE JONES</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME <u>EVANS OWENS, MT. VIEW MO.</u>	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarction due to Arteriosclerotic Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		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) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>5/14</u> , 19 <u>53</u> , to <u>5/18</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>53</u> , and that death occurred at <u>6:40 A.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>William J. Paul</u>		23b. ADDRESS <u>609 Cherry, Springfield Mo.</u>		23c. DATE SIGNED <u>5/19/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5/18/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>	
24d. LOCATION (City, town, or county) (State) <u>Mountain View, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. LOHMEYER</u>			
DATE REC'D BY LOCAL REG. <u>5/20/53</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		ADDRESS <u>SPRINGFIELD, MO.</u>	

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

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DUNCAN Funeral Home
Mountain View, Mo

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 Lucien L. Swadlow

Licensed Embalmer No. 4815

P. O. Address Springfield

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.