

FILED JAN 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43323
State File No. _____
5759

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Jackson	
b. CITY OR TOWN Kansas City		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 514 1/2 Main St.		e. STREET ADDRESS 514 1/2 Main St.		3028	

3. NAME OF DECEASED (Type or Print) FRED			a. (First)			b. (Middle)			c. (Last) HOWARD			4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1955			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 9		8. DATE OF BIRTH 9			9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months		IF UNDER 1 HR. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 9				10b. KIND OF BUSINESS OR INDUSTRY 9				11. BIRTHPLACE (City and State or Foreign Country) 9				12. CITIZEN OF WHAT COUNTRY? 9			

13a. FATHER'S NAME 9			13b. MOTHER'S MAIDEN NAME 9			14. NAME OF HUSBAND OR WIFE 9		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 9		16. SOCIAL SECURITY NO. 9		17. INFORMANT'S SIGNATURE OR NAME Coroner's office K-C Mo				ADDRESS	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death not known						INTERVAL BETWEEN ONSET AND DEATH 79¹⁵	
		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.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION no part permit						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. OWENS		(Degree or title) 3		23b. ADDRESS 1034 Park St. Bldg		23c. DATE SIGNED 12-24-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 1-3-56		24c. NAME OF CEMETERY OR CREMATORY St. Calvary		24d. LOCATION (City, town, or county) (State) K.C. Kans	
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DATE REC'D BY LOCAL REG. 1-3-56		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE David B. [Signature]		ADDRESS K.C. Mo.	
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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..

Student.....
Signature of Student Embalmer

Signed.....
[Handwritten Signature]

Licensed Embalmer No.....
[Handwritten Number]

P. O. Address.....
[Handwritten Address]

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.