

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48
FILED MAR 12 1956

BIRTH NO. _____		REG. DIST. NO. <u>42</u>	PRIMARY REG. DIST. NO. <u>1000</u>	Registrar's No. <u>244</u>
1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) life	c. CITY OR TOWN St. Joseph	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 522 No. 9th St.		e. STREET ADDRESS (If rural, give location) 522 N. 9th St.		
3. NAME OF DECEASED (Type or Print) a. (First) MARYBELLE		b. (Middle) BLANCHE	c. (Last) OWEN	4. DATE OF DEATH (Month) (Day) (Year) February 28, 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH May 14, 1911	9. AGE (In years last birthday) 44 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME J. L. Bear		13b. MOTHER'S MAIDEN NAME Susan Bell	14. NAME OF HUSBAND OR WIFE Ralph B. Owen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 500-07-9962	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ralph Owen, 522 N. 9th, St. Joseph, Mo.	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast with generalized metastasis 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 5 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 170x		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?		
22. I hereby certify that I attended the deceased from <u>2-24</u> , 19 <u>56</u> , to <u>2-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>56</u> , and that death occurred at <u>3:30a.</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Joseph L. Fisher M.D.		23b. ADDRESS 824 Edmund St., City	23c. DATE SIGNED 2-29-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3/2/1956	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG. Mar 6, 1956	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 489 N. Benton - Bowman St. Joseph, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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 *James B. Hawkins*.....

Licensed Embalmer No. *4531*

P. O. Address *319 E. 10th St.*

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.