

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4002

FILED FEB 27 1956

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Monroe County</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Fulton, Mo.</u> )		c. CITY OR TOWN <u>New Monroe City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>24 da</u>		e. STREET ADDRESS (If rural, give location) <u>D.K.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>State Hospital #1, Fulton, Mo.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JOHN</u>	b. (Middle) <u>R.</u>	c. (Last) <u>OWEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 22, 1956</u>
-------------------------------------	------------------------	-----------------------	-----------------------	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 31, 1874</u>	9. AGE (In years) (Month) (Day) (Year) <u>81 8 21</u>	IF UNDER 1 YEAR Days <u>21</u>	IF UNDER 1 HRS. Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	--------------------------------------	---	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City, and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Isaac Layson Owen</u>	13b. MOTHER'S MAIDEN NAME <u>Abigail Dawson</u>	14. NAME OF HUSBAND OR WIFE <u>Emma E. Owen</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>D.K.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records of State Hospital #1, Fulton, Mo.</u>	ADDRESS <u>Fulton, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN INTENT AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho Pneumonia,</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis,</u> DUE TO (c) <u>Arteriosclerosis</u>		<u>D.K.</u> <u>D.K.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>446x</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) <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 1-30-56, 1956, to 2-21, 1956, that I last saw the deceased alive on Feb 21, 1956, and that death occurred at 9:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ralf. Hanks, m.d., by F. H. Nichol, m.d.</u>	23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>	23c. DATE SIGNED <u>2-22-56</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>2-24-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Jude's Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Monroe City, Mo.</u>
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Feb. 23-1956</u>	REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	426	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wilson &amp; Sons</u>	ADDRESS <u>Monroe City, Mo.</u>
--	---	-----	---	---------------------------------

(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 *Leona L. Nelson*.....

Licensed Embalmer No. *7015*

P. O. Address *Grand*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E  
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.