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Health, Welfare, Public Service

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 2-1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

81017

STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 4158 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>DALLAS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>DALLAS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BUFFALO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>BUFFALO 0300</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <u>95 yrs</u>	d. STREET ADDRESS (If outside, give location)			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>ELLEN</u> Last <u>McKOWN</u>				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 18 1862</u>		9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>A.H. Freeman</u>				14. MOTHER'S MAIDEN NAME <u>Unkown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Estella Strickland, Buffalo, MO.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility - 97 yrs of age</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>3-20-57</u> to <u>3-28-57</u> and last saw <u>her</u> alive on <u>3-28-57</u> . Death occurred at <u>4</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>D.O. Jannina M.D.</u> (Degree or title)				22b. ADDRESS <u>Buffalo Mo.</u>		22c. DATE SIGNED <u>3-29-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>3-31-57</u>	<u>Oak Lawn</u>		<u>Buffalo, MO.</u>			
24. FUNERAL DIRECTOR <u>Montgomery Funeral Home</u> ADDRESS <u>Buffalo Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4/1/57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Grace Peters</u>		

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 *Clyde Montgomery*.....
Licensed Embalmer No. *357*

P. O. Address *Buffalo,*.....

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