

FILED JUN 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17131  
STATE FILE NUMBER  
2410

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2410

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rural Jackson County, Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph's Hospital</b>		Length of stay in lb <b>4 days</b>		d. STREET ADDRESS (If outside, give location) <b>11411 Greenwood Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Margery</b> Middle <b>Dee</b> Last <b>HOWER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-1925</b>	9. AGE (In years last birthday) <b>31</b>	F UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Richard Wackernagle</b>		13b. MOTHER'S MAIDEN NAME <b>Mable Griggs</b>		14. NAME OF HUSBAND OR WIFE <b>Oral Glen Hower (Dec)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>491-24-7265</b>	17. INFORMANT Address <b>Mrs. Betty Crawford, Savannah, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>fractured skull for spine</b> DUE TO (b) <b>numerous abrasions &amp; lacerations</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>8934D</b>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Injured in Tornado</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <b>5-20-57</b> p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Hickman with Jackson Mo</b>		20g. COUNTY STATE <b>MO</b>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title)			22b. ADDRESS <b>Corner 1034 Piatto Bldg</b>		22c. DATE SIGNED <b>5-24-57</b>
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Removal</b>		23b. DATE <b>May 24 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Savannah Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>John P Sheil Kansas City Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>5-24-57</b>	26. REGISTRAR'S SIGNATURE <b>new murray</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Hugh H. Owens

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



JUN 12 1957

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 *Harold P. Reich* .....

Licensed Embalmer No. *4998* .....  
P. O. Address. *Kansas City,* .....

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.