

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36502
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 4264 Registrar's No. 177

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Conway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Conway Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ----- HOME		Length of stay in 1b 49 yrs.	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Owens			4. DATE OF DEATH Month Oct. Day 21 Year 1957	
--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1878	9. AGE (In years (by birthday)) 79	FUNDER 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 Home	11. BIRTHPLACE (City and state or country) Grove Spring, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	--	---

13a. FATHER'S NAME Jess Climer	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE George Owens
--	---	--

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. None	17. INFORMANT Address Mrs. Verbia Chapman, Conway, Mo.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ----- 260X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT <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 10-4-57 , to 10-21-1957 and last saw ^{her} him alive on 10-4-57 Death occurred at 9:15 a. m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE J. W. Lindsey (Degree or title)	22b. ADDRESS Conway, Mo.	22c. DATE SIGNED 10-27-57
--	------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county). (State)
Burial	10-24-1957	Conway Cemetery	Conway, Missouri

24. FUNERAL DIRECTOR Jamie ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 10-28-1957	26. REGISTRAR'S SIGNATURE Hella L. May
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Received on 11-4-57

Laclede County Health Unit

File No. 177

Date Filed 11-4-57

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 [Signature]

Licensed Embalmer No. 3312

P. O. Address: Springfield, Mo

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.