

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018412

STATE FILE NUMBER

FILED MAY 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2100

5. 300  
1-57

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

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>CLAY</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>KANSAS CITY NORTH</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Length of stay in hospital <b>2 1/2 hours</b>	d. STREET ADDRESS (If outside, give location) <b>4709 Winn Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>NEIL (NONE) OWENS</b>			4. DATE OF DEATH Month Day Year <b>April 21, 1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1889</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and state or country) <b>SUMMERSET, KENTUCKY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. NAME OF HUSBAND OR WIFE <b>Elizabeth E. Owens</b>	
13a. FATHER'S NAME <b>THOMAS J. OWENS</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH HARRIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>486-03-2624</b>	17. INFORMANT Address <b>Official Records VA Hospital, K.C., 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>CEREBRAL THROMBOSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>332x</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE OLD MYOCARDIAL INFARCTION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE OLD MYOCARDIAL INFARCTION</b>			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 Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>April 21, 1958</b> to <b>April 21, 1958</b> and last saw him/her alive on <b>April 21, 1958</b> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <b>11:20 P.M.</b>			
22a. SIGNATURE <b>W. W. WOODWARD, M.D.</b>		22b. ADDRESS <b>M. D. VA Hospital, K.C., Mo.</b>	
22c. DATE SIGNED <b>4-22-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WHITE CHAPEL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>GLADSTONE, MISSOURI.</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMERS, North Kansas City</b>		25. DATE RECD. BY LOCAL REG. <b>4-24-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>



**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 *Glenn A. Hill* .....

Licensed Embalmer No. *4586*

P. O. Address *K.C. 16, 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.