THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044324
STATE FILE NUMBER

FILED DEC 30 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5881

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) QUEEN OF THE WORLD — Length of stay in 1b —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
d. STREET ADDRESS 2705½ BELL ~~KOMO~~ (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First CLARA Middle Last OWENS
4. DATE OF DEATH Month DECEMBER Day 10, Year 1958
5. SEX FEMALE
6. COLOR OR RACE NEGRO
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/17/1898
9. AGE (In years last birthday) 59 — IF UNDER 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) House Work
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (City and state or country) Garrison TEXAS
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert Hill
14. MOTHER'S MAIDEN NAME Minnie Green
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT WELBERT OWENS, SON Address 3244 VICTOR K.C. MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage ; Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive cardiovascular disease — 10-12 mo.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4 [illegible]
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 12/3/58, to 12/10/58 and last saw her/him alive on 12/10/58
Death occurred at 10:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Helen Starke, M.D.
22b. ADDRESS 3210 E. 23rd. St. K.C. Mo.
22c. DATE SIGNED 12/11/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12/12/1958
23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Mrs. J. W. Jones ADDRESS 440 state ave. Kans.
25. DATE RECD. BY LOCAL REG. 12-12-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Helen Starke

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Eugene English

Licensed Embalmer No. 41

P. O. Address 440 St

K. C.

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.