

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012663

STATE FILE NUMBER

FILED APR 23 1959 Registration District No. 70 Primary Registration District No. Registrar's No. 19

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Clark</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Clark</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Revere</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>Kahoka</i> 03 30 0 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Shuler Rest Home</i> | | Length of stay in lb <i>1 yr</i> | 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 Middle Last <i>Amelia Elvora Owen</i> | | | 4. DATE OF DEATH Month Day Year <i>April 3. 1959</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 18-1874</i> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nursekeeping</i> | | 9b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years) (If UNDER 1 YEAR, give Months Days Hours Min.) <i>84</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nursekeeping</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <i>Missouri</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13a. FATHER'S NAME <i>Michael Courtney</i> | |
| 13b. MOTHER'S MAIDEN NAME <i>Katherine Evans</i> | | 14. NAME OF HUSBAND OR WIFE <i>Samuel Owen</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Harry Owen - Kahoka Mo.</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Apoplexy, Cerebral</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) | | | 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.) <i>334X</i> | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 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 _____, 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 (Degree or title) <i>J. L. McNeill M.D.</i> | | 22b. ADDRESS <i>Revere Mo</i> | 22c. DATE SIGNED <i>4-10-59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>April 6-1959</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Kahoka Co.</i> | 23d. LOCATION (City, town, or county) (State) <i>Kahoka Mo.</i> |
| 24. FUNERAL DIRECTOR <i>Oliver L. Tuttle - Kahoka</i> | | 25. DATE RECD. BY LOCAL REG. <i>4/13-59</i> | 26. REGISTRAR'S SIGNATURE <i>J. A. Bridges</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Oliver L. Tuttle*

Licensed Embalmer No. *2969*
P. O. Address *Lahaina*

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.