

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012782
STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 93 Primary Registration District No. Registrar's No. 59-37

300
1-57

| | | | | | |
|---|-----------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Dade | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greenfield Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Greenfield Mo. | | 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 lb 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 Eva Middle Owens Last Owens | | | 4. DATE OF DEATH Month April Day 25 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7 1889 | 9. AGE (In years last birthday) 69 IF UNDER 1 YEAR: Month 11 Days 18 IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Greenfield Mo | | 12. CITIZEN OF WHAT COUNTRY? usa |
| 13a. FATHER'S NAME Walter Dicus | | 13b. MOTHER'S MAIDEN NAME Ma ry Hailey | | 14. NAME OF HUSBAND OR WIFE Lloyd 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 Lloyd Owens Greenfield 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) <u>GENERALIZED TOXEMIA (CARCINOMA)</u> DUE TO (b) <u>UTERINE CARCINOMA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 174x | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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. INJURY OCCURRED WHILE AT WORK <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 <u>JAN 1959</u> to <u>APRIL 25 1959</u> and last saw her alive on <u>APRIL 20 1959</u> Death occurred at <u>APRIL 25 1959 9:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>M. K. Lande Schwantz M.D.</i> | | | 22b. ADDRESS <i>Greenfield, Mo</i> | | 22c. DATE SIGNED <i>7-30-59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>April 28 1959</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Greenfield ..</i> | | 23d. LOCATION (City, town, or county) (State) <i>Greenfield Mo</i> |
| 24. FUNERAL DIRECTOR <i>W. R. Allison</i> | | ADDRESS <i>Greenfield Mo</i> | 25. DATE RECD. BY LOCAL REG. <i>May 1, 1959</i> | | 26. REGISTRAR'S SIGNATURE <i>J. C. Canada</i> |

All diseases in Part I must be causally related.

M.K.Lande Schwantz, MD ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W.R. Allison*

Licensed Embalmer No. *4407*
P. O. Address *Greenville*

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.