Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012985
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 128 Primary Registration District No. 2070 Registrar's No. 401

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Burge Hospital — Length of stay in Ib:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN: Springfield 0396 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1400 Sherman — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JOHN Middle: S. Last: OWEN

4. DATE OF DEATH Month: April Day: 18, Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 15 February 1882

9. AGE (In years last birthday): 77 — 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): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: William Owen

13b. MOTHER'S MAIDEN NAME: Renfro

14. NAME OF HUSBAND OR WIFE: Effie Owen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records — Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 334X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 3-20-58, to 4/18/59 and last saw him alive on 4/17/59
Death occurred at 3:25 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) M.D.

22b. ADDRESS Medical Arts Building Springfield, Missouri

22c. DATE SIGNED 4-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4-21-59

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn

23d. LOCATION (City, town, or county) (State): Springfield, Missouri

24. FUNERAL DIRECTOR ADDRESS: J.W. KLINGNER & CO. SPRINGFIELD, MO.

25. DATE RECD. BY LOCAL REG.: 4-22-59

26. REGISTRAR'S SIGNATURE: Effie G. Mellen

APR 27 1959

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 .....

Licensed Embalmer No. 4075

P. O. Address .....

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.