

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028255

FILED VS AUG 24 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 845

STATE FILE NUMBER

FILED

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Joseph</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2116 S. 10th</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>D.</u> Last <u>Owens</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1959</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-10-1881</u>		9. AGE (last birthday) <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Lee Co. Va</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>			
13a. FATHER'S NAME <u>Van Owens</u>			13b. MOTHER'S MAIDEN NAME <u>unknowen</u>			14. NAME OF HUSBAND OR WIFE <u>Arbin Owens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Arbin Owens, Maryville, Mo</u> 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) <u>Chronic Lymphatic Leukemia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>	
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ a.m. _____ p.m.		Month, Day, Year							
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>7/26/59</u> to <u>8/13/59</u> and last saw him ^{hacc} alive on <u>8/12/59</u> Death occurred at <u>9:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Arbin Owens MD</u>				22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u>				22c. DATE SIGNED <u>8/14/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/15/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barnard Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Barnard Mo</u>			
24. FUNERAL DIRECTOR <u>McIntosh Maryville Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 17, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Clark Sandell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed G M Peterson

Licensed Embalmer No. 2579

P. O. Address Mojo

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.