

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028433

FILED VS SEP 11 1959

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. 141

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Peculiar Twp.</u>		Length of stay in 1b <u>5 years</u>	c. CITY OR TOWN <u>Drexel</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant View Rest Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>✓</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle _____ Last <u>McKOWN</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11 1866</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Roy Bell Lumber Co</u>	11. BIRTHPLACE (City and state or country) <u>Galesburg, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>A. J. McKown</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Holloway</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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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>487-12-5586</u>	17. INFORMANT <u>Robert Dorothy Armstrong RCM</u>	Address <u>750W 47th</u>
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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>Toucheut Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</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) <u>Scurvy, Arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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 _____
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21. I attended the deceased from March 1955 to 8-29-59 and last saw her alive on 8-29-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edwards-Jones, md</u> (Degree or title)	22b. ADDRESS <u>Harrisonville, Mo</u>	22c. DATE SIGNED <u>8-31-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 30 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>West Line Mo</u>
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24. FUNERAL DIRECTOR <u>Armenburg's Harrisonville Mo</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>Aug 30 1959</u>	26. REGISTRAR'S SIGNATURE <u>ms Ray Sebr</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

James R. Phillips

Licensed Embalmer No. 4641

P. O. Address Harrisonic

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.