

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 4 2 8 8

FILED VS JAN - 6 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6094

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>48 yrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SWOPE RIDGE NURSING HOME</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3317 PENN</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARY K. OWELLS</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>16</b> Year <b>1959</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 15, 1878</b>		9. AGE (last birthday) <b>81 YRS.</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>DALLAS TEXAS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>HENRY KENNEDY</b>			13b. MOTHER'S MAIDEN NAME <b>LAURINDA MILLER</b>			14. NAME OF HUSBAND OR WIFE <b>A. C. OWELLS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. WALTER SEBUS 3317 PENN</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pt. Cerebral Hemorrhage</b>							7 mo. <b>revised</b>		
DUE TO (c) <b>Generalized arteriosclerosis</b>							<b>Yes.</b>		
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 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 <b>May 1939</b> to <b>12/15/59</b> and last saw her <sup>her</sup> alive on <b>12/15/59</b> Death occurred at <b>9:15 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>John M. Powers, M.D.</b>					22b. ADDRESS <b>3304 Linwood</b>		22c. DATE SIGNED <b>12/18/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC 19, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K.C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>12-18-59</b>		26. REGISTRAR'S SIGNATURE <b>neva mindall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John M. Powers

**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 Roger L. Lally

Licensed Embalmer No. 4818

P. O. Address K.C. Mo.

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.