

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023590

FILED VS JUN 28 1960

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 319

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Cherokee</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Length of stay in 1b		c. CITY OR TOWN <u>Galena</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>St. Johns Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>708 E. 5th Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Harrison</u> Last <u>Owen</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept/6, 1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Dealer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Licking, Missouri</u>		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME <u>Oliver Owen</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Freeman</u>			14. NAME OF HUSBAND OR WIFE <u>Rella Mae Owen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>495-36-4100</u>		17. INFORMANT 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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</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 checked="" type="checkbox"/> NO <input 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 <u>9 June 60</u> to <u>23 June 60</u> and last saw her <u>her</u> him alive on <u>23 June 60</u> Death occurred at <u>1 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Norman H. Bannard, M.D.</u> (Degree or title)				22b. ADDRESS <u>205 Medical Center</u>			22c. DATE SIGNED <u>24 June 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osborne Cemetery</u>			23d. LOCATION (City, town, or county) <u>Joplin</u>		23e. (State) <u>Missouri</u>		
24. FUNERAL DIRECTOR <u>Hurlbut-Glover Mortuary-Joplin, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>6-24-1960</u>		26. REGISTRAR'S SIGNATURE <u>Noel Merriam</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 Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb

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.