

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

LED VS SEP 7 1960

-60-031278

STATE FILE NUMBER

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 69-60

1. PLACE OF DEATH a. COUNTY <u>McDonald</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>McDonald</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Anderson</u>		Length of stay in 1b <u>10 yrs</u>	c. CITY OR TOWN <u>Anderson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RT 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RT 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Stehha MAE OWENS</u>			4. DATE OF DEATH Month Day Year <u>8-24-1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3-2-1919</u>	9. AGE (last birthday) <u>41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (City and state or country) <u>Buckhannon, W. Va</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>ARTHUR R. SHUDER</u>		13b. MOTHER'S MAIDEN NAME <u>Luha JOHNSON</u>		14. NAME OF HUSBAND OR WIFE <u>SAM 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>NONE</u>		17. INFORMANT Address <u>Jim OWENS, Anderson Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>acute viral pneumonia</u>		
	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	
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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.)	
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 checked="" 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 6:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. F. Stiles, D.O.</u>	22b. ADDRESS <u>Turner, Mo.</u>	22c. DATE SIGNED <u>8-31-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-27-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANDERSON CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ANDERSON Mo</u>
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24. FUNERAL DIRECTOR <u>Humphrey &amp; Son &amp; Home M.H.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 1, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mary A. Bradley</u>
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(Licensed Embalmer's Statement on Reverse Side) Ref. W. F. STILES, D.O.

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Mayne E. Humphreys

Licensed Embalmer No. 426

P. O. Address Pineville

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to  
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.