

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033463

FILED VS SEP 12 1960 324

Registration District No. _____ Primary Registration District No. 6086 Registrar's No. 160

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY: Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Illinois COUNTY: Madison						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SALT FORK TOWNSHIP		Length of stay in 1b INSTANTANEOUS		c. CITY OR TOWN: Venice		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION: 9 Miles SE Marshall, Mo			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 625 Lincoln		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: STELLA Middle: LEONA Last: OWENS				4. DATE OF DEATH Month: Sept. Day: 4 Year: 1960						
5. SEX: Female		6. COLOR OR RACE: White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH: 10/26/1902		9. AGE (last birthday): 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (City and state or country) Saline City, Mo.		12. CITIZEN OF WHAT COUNTRY USA		IF UNDER 1 YEAR Months: _____ Days: _____		
13a. FATHER'S NAME Robert Lee Johnson			13b. MOTHER'S MAIDEN NAME Mary Catherine Mattix			14. NAME OF HUSBAND OR WIFE Frank Owens			IF UNDER 24 HR Hours: _____ Min: _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 487-01-5677		17. INFORMANT Address: Eva Gibbons, Slater, Missouri					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken Neck, Multiple Bursitis								INTERVAL BETWEEN ONSET AND DEATH Inst.		
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 checked="" 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.) Car missed culvert and went into 20 ft. ditch.						
20c. TIME OF INJURY 7:45 p.m.		Month, Day, Year 9-4-60		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.) 2 Miles east Blue Lick - 9 Miles S. + E. of Marshall		20f. CITY, TOWN, OR LOCATION Saline Mo		
21. I attended the deceased from death occurred at 7:45 p.m. 9-4-60		I made investigation 9-5-60		and last saw her/him alive on _____						
22a. SIGNATURE P.L. Louless MD				(Degree or title) Physician Saline Co		22b. ADDRESS Marshall Mo		22c. DATE SIGNED 9-5-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/7/1960		23c. NAME OF CEMETERY OR CREMATORY Slater		23d. LOCATION (City, town, or county) Slater, Mo.		(State)		
24. FUNERAL DIRECTOR Haines Funeral Home, Slater, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 9-6-'60		26. REGISTRAR'S SIGNATURE Paul G. Read		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 12 1962

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 Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Slater

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.