

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046635

FILED VS DEC 29 1960

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559V Registrar's No. 165

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	JEFFERSON	a. STATE	MO. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	RURAL JOACHIM	c. CITY OR TOWN	FESTUS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	JEFF. MEMORIAL HOSPITAL	d. STREET ADDRESS	R#3

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	ROY		OWEN	DECEMBER	12	1960	

5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
MALE	WHITE		2-16-1889	71	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
retired salesman	SALES	OWENSBORO, KY.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
THOMAS GRANT OWEN	EUNICE JOHNSON	JESSIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address
		MRS. JESSIE OWEN FESTUS, MO. R#3

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) <i>moderate alcohol</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>acute peritonitis</i>	
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 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	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
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21. I attended the deceased from *Dec 11 60* to *Dec 12 60* and last saw her/him alive on *Dec 12 60*
 Death occurred at *9 p.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <i>[Address]</i>	22c. DATE SIGNED <i>[Date]</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	12-14-60	GAMEL	FESTUS MO.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
GENTRY R. POLITTE CRYSTAL CITY, MO.	12-14-60	<i>[Signature]</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 29 1960

FEB 24 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

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

Student _____
Signature of Student Embalmer

Signed Henry R. Tolson

Licensed Embalmer No. 3481

P. O. Address Crystal

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