

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045891

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 294 Primary Registration District No. 2056 Registrar's No. 2 STATE FILE NUMBER

FILED JAN 12 1962

1. PLACE OF DEATH
 a. COUNTY RANDOLPH
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MOBRLY Length of stay in lb 2 1/2 DAYS
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION WOODLAND HOSP. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MO b. COUNTY MONROE
 c. CITY OR TOWN JACKSON TWP. Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 6 MI. S.W. OF PARIS, MO. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
HAROLD (L.D.) OWINGS

4. DATE OF DEATH Month Day Year
12-30-1961

5. SEX M 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 1/30/1911 9. AGE (last birthday) 50

IF UNDER 1 YEAR: Months 11 Days - IF UNDER 24 HR: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (City and state or country) CANTON, MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME STEPHEN B. OWINGS 13b. MOTHER'S MAIDEN NAME RUBY CHILCOTE 14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Address MARY E. OWINGS R-3 PARIS, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Peritonitis, generalized INTERVAL BETWEEN ONSET AND DEATH 7 days
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ruptured diverticulum colon 7 days
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 16.) _____

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Dec 28-1961 to Dec 30 and last saw him alive on Dec 30
 Death occurred at 9:30 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS Mo. Mobry Mo. 22c. DATE SIGNED 12/31/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 1/1/62 23c. NAME OF CEMETERY OR CREMATORY WALNUT GROVE 23d. LOCATION (City, town, or county) (State) PARIS, MO.

24. FUNERAL DIRECTOR ADDRESS E. H. AGNEW PARIS, MO. 25. DATE RECD. BY LOCAL REG. 1-1-62 26. REGISTRAR'S SIGNATURE [Signature]

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 Robert E. Wood, Student Embalmer No. 653

working under my personal supervision.

Student Robert E. Wood
Signature of Student Embalmer

Signed E. W. Agnew,

Licensed Embalmer No. 4000

P. O. Address Paris, 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.