

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034435
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1447

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 1 1962	
1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in lb <u>Life</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Protestant Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>2511 N. Lyon (Parents)</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <u>Deborah</u> Middle <u>Ann</u> Last <u>Owen</u>	
4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-1962</u>
9. AGE (last birthday) <u>--</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>
11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Donald Wayne Owen</u>	13b. MOTHER'S MAIDEN NAME <u>Anita Marie Jordan</u>
14. NAME OF HUSBAND OR WIFE -----	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 <u>D. W. Owen, Springfield, Missouri</u> 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>Anencephalic monster</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min</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 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 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>9-25-62</u> to <u>9-25-62</u> and last saw her alive on <u>9-25-62</u> Death occurred at <u>12:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>John P. Ferguson M.D.</u> (Degree or title)	22b. ADDRESS <u>Springfield Mo.</u>
22c. DATE SIGNED <u>9-27-62</u>	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE <u>9-26-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>
24. FUNERAL DIRECTOR <u>Rainey's Chapel, Springfield, Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>9-28-62</u>
26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	_____

VS 300 Rev. 4/59
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Print 5-26-62

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

Embalmed