

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0006104

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

MR FILED 009 64

Primary Registration District No. 5510

Registrar's No.

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Highway 77</u>		c. CITY OR TOWN <u>Independence</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Highway 77 Near Country Line</u>		d. STREET ADDRESS (If outside, give location) <u>611 Westwood</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE WINFORD OWINGS</u>		4. DATE OF DEATH Month Day Year <u>March 7 1964</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>1-25-1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		11. BIRTHPLACE (City and state or country) <u>Oak Grove Mo</u>	
13a. FATHER'S NAME <u>Percy Morris</u>		14. NAME OF HUSBAND OR WIFE <u>Troy 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>		17. INFORMANT Address <u>496-10-4770 Troy Owens Independence Mo</u>	
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>Compound Fracture of Skull</u> DUE TO (b) <u>with extrusion Brain Substance</u> DUE TO (c) <u>Mild Frontal area</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple Facial Bone Fractures, Compound</u>		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.) <u>2 vehicle accident</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>7 a.m. 3-7-64</u>		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.) <u>Highway 13 - Detour Mo.</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Highway 13 - Detour Henry Mo.</u>	
21. I attended the deceased from <u>unattended</u> to <u>unattended</u> and last saw her/him alive on <u>approx 7 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wilfred H. King M.D.</u>		22b. ADDRESS <u>1065-3rd Clinton Mo.</u>	
22c. DATE SIGNED <u>3-7-64</u>		22d. LOCATION (City, town, or county) (State) <u>Independence Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-7-64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OTT & Mitchell Funeral Home</u>	
24. FUNERAL DIRECTOR <u>E.L. SCHABER</u>		25. DATE RECD. BY LOCAL REG. <u>MAR. 7, 1964</u>	
26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

1578580

14 00011 1964

MAR 20 1964

APR 16 1964

MAR 11 1964

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 _____

F. L. Schenberg

Licensed Embalmer No.

4513

P. O. Address

Clinton 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.

Permit Obtained

3-7-64

(145)