

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jackson  
Township Kanaw  
or  
Village \_\_\_\_\_  
or  
City Kansas City Mo. (NO. German Hosp St.: \_\_\_\_\_ Ward)

Registration District No. 399 File No. 4815  
Primary Registration District No. 1002 Registered No. 532

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Oscar Owen

PERSONAL AND STATISTICAL PARTICULARS.

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Nov. 27, 1889</u> (Month) (Day) (Year)		
AGE <u>25</u> yrs. <u>2</u> mos. <u>16</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Teaming</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE (City or town, State or foreign country) <u>Lexington Mo</u>	
PARENTS	NAME OF FATHER <u>James Owen</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>
	MAIDEN NAME OF MOTHER <u>Fannie Roblitt</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fannie Roblitt  
(ADDRESS) Lexington Mo.

Filed Peb. 13 1915 1915  
M.S. Wheeler  
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 12, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 28, 1915, to Feb 17, 1915, that I last saw him alive on Feb 12, 1915, and that death occurred, on the date stated above, at 800 m.

The CAUSE OF DEATH\* was as follows:  
Typhoid fever  
103B 01  
(Duration) yrs. 1 mos. \_\_\_ ds.

Contributory Human legs & Refraction  
(SECONDARY) (Duration) yrs. \_\_\_ mos. 6 ds.  
(Signed) J. Chambers M. D.  
2/13, 1915 (Address) 800 Realty Bldg

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. 16 ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death? Lexington, Mo  
Former or usual residence Lexington, Mo.

PLACE OF BURIAL OR REMOVAL <u>Lexington Mo</u>	DATE OF BURIAL <u>Feb. 14, 1915</u>
UNDERTAKER <u>John A. Wagner</u>	ADDRESS <u>1409 Grand ave.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

