LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County Greene

Township Wilson or Village or City

Registration District No. 317 File No. 39160

Primary Registration District No. 5442 Registered No.

(NO. Battlefield R.F.D. #1 St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Lewis Owen

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May (Month) 7 (Day), 1880 (Year)

7 AGE 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Greene Co. Mo

PARENTS

10 NAME OF FATHER Charles B. Owen

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn

12 MAIDEN NAME OF MOTHER Caroline McCrosky

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles J. Owen
(Address) Spfld Route #8

15 Filed 11-15, 1918 W C Carter Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Nov (Month) 8th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 2, 1918, to Nov. 8, 1918, that I last saw him alive on Oct 8, 1918, and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:

Influenza
11 P
10 P
10

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) J. C. Matthews M. D.

Nov. 8, 1918 (Address) Springfield Mo.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Owen Graveyard

DATE OF BURIAL 11-9, 1918

20 UNDERTAKER Paxson Mud Co.

ADDRESS 410 South St

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

**1 PLACE OF DEATH**

County .....

Township..... Registration District No..... File No. .....
*or*
Village ..... Primary Registration District No. ..... Registered No. .....
*or*
City..... (NO....., .....St.:.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... ....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....,

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS

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.