SEP 27 1927

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

Do not use this space.

23800

1. PLACE OF DEATH

County: Carroll — Registration District No. 135

Township: — Primary Registration District No. 3010

City: Carrollton (No. ..... St. ..... Ward)

File No. .....

Registered No. 64

2. FULL NAME Hamilton Owens

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Frances Ruppert Owens

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 5-15-1867

7. AGE: Years 60 | Months 2 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER: Hector Owen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

12. MAIDEN NAME OF MOTHER: Nancy Saunders

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

14. INFORMANT: Mrs Hamilton Owens
(Address) Carrollton Mo

15. FILED 8-6, 1927 Mrs. E E Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-5 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-1-27, 19..., to 8-5, 1927 that I last saw him alive on 8-4-27, 19..., and that death occurred, on the date stated above, at 11:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: pernicious Anemia

71A 58A (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED —

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? — DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Blood Smears

(Signed) H. B. Scovern, M. D

8-6, 1927 (Address) Carrollton, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Pleasant Hill Cem

DATE OF BURIAL: 8-7 1927

20. UNDERTAKER: Standley Fun. Home

ADDRESS: Carrollton

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.