

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

Do not use this space. 1341

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
Township Kaw Primary Registration District No. 1002 Registered No. 305
City Kansas City (No. 3708 East 17th Street) St. _____ Ward _____

2. FULL NAME Emma Isabell Owens.

(a) Residence. No. 3708 East 17th St. 11 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 11 How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. H. Owens

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 27-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 2 28

B. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Not Known
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER William Walker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Miss Maken
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Missouri

14. INFORMANT J. H. Owens
(Address) 3708 East 17th St.

15. FILED Jan 26 1928 M. M. Casper
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 25, 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1928, to Jan 25 1928, that I last saw her alive on Jan 25 1928, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
(duration) yrs. mos. ds. 14

CONTRIBUTORY Phenacetin
(SECONDARY) (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH

5 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) W. L. Ray, M. D.

1-26 1928 (Address) 321 Altman Bldg
*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 Jefferson City Mo. DATE OF BURIAL 1/28 1928

20. UNDERTAKER The Taylor Funeral Home Inc. Kansas City, Mo. 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.

