

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. Invent to Hosp)
 File No. 18726
 Registered No. 5120
 St. Ward)

2. FULL NAME

Mary Owens
 (a) Residence. No. 5150 E. Main St., 6 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

Female White single
 5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 17 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 7 21 = min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Thomas Owens

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

12. MAIDEN NAME OF MOTHER Jane Kelly

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

14. INFORMANT Mrs. Catherine E. Ellison
 (Address) 5150 E. Main

15. FILED May 12 1928 Mary C. Standiford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-8-28 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at 1045 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fracture skull
 (duration) yrs. mos. da.
 CONTRIBUTORY Shock by auto in City
 (secondary) of St. Louis (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF OPERATION 1881

19. WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Wm. Dever M.D.
710 (Address) Dep. Coroner

*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 Calvary DATE OF BURIAL 5-11 1928

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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