

Bureau of Vital Statistics
CERTIFICATE OF DEATH

39168

County Stone
 Township Alpine - 22 Registration District No. 441 File No. _____
 Inc. Town of _____ Primary Registration District No. 6255 Registered No. _____
 City Shell Knob, Mo. (No. _____) St.; _____ Ward _____

2 FULL NAME James Clement 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 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 Margarette Virginia Hilton
 6 DATE OF BIRTH June 18th 1852
 Month Day Year

7 AGE Years Months Days If LESS than 1 day,.....hrs. or.....min.
76 76 4 13

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

9 BIRTHPLACE (city or town) Granby
 (State or country) Missouri

10 NAME OF FATHER William H. Owens.

11 BIRTHPLACE OF FATHER (city or town) Tennessee
 (State or country) _____

12 MAIDEN NAME OF MOTHER Sarah Ann McCreay

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country) Georgia

14 Informant Margarette V. Owens.
 (Address) Shell Knob, Mo.

15 Filed 11-1-1928 J. Schaffel
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11-1-1928
 Month Day Year

17 I HEREBY CERTIFY, That I attended deceased from 5-10-1927 to 11-1-1928, 1928
 that I last saw him alive on 10-10-1928, 1928
 and that death occurred, on the date stated above, at 6:30 a.m.
 The CAUSE OF DEATH was as follows:
 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. (See reverse side for additional space.)

Organic heart (myocardial) Regurgitation and High blood pressure.
 (duration) 3 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 _____
 What operation performed? _____

Was there an autopsy? _____
 What test confirmed diagnosis? _____

(Signed) A. L. Doster M. D.
11-1-1928 (Address) Berryville

19. PLACE OF BURIAL, CREMATION, or REMOVAL _____ DATE OF BURIAL _____
 19 _____

20 UNDERTAKER _____ ADDRESS _____

Burial or Transit Permit issued by _____ Date of issue _____

MARGIN RESERVED FOR BINDING

3 1928
 N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.
 V. S. No. 4

(Approved by

U. S. Census and American Public Health Association)

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse,"

"Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

Note.—Certificates may be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Stone
Township Alpine
City Walter

Registration District No. 847
Primary Registration District No. 61R6 255

File No.
Registered No.
St. Ward)

2. FULL NAME

James Clement 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 yrs. 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) M

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

PARENTS

14. INFORMANT (Address)

15. FILED 11-1-1928 J. S. Haffell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-1-1928

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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D. , 19 (Address)

*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 DATE OF BURIAL 11-2-1928

Owens County ADDRESS Shelby Knott

20. UNDERTAKER John Nelson

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, in PLAIN TERMS, and not in terms of months, weeks, or days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given.

SUPPLEMENTARY

S-39168