

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

Do not use this space.

7238

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Township Marion Primary Registration District No. 3079 Registered No. 52
 City Hannibal (No. 700 North Section) St. _____ Ward _____

2. FULL NAME

William Henry Owen
 (a) Residence No. 700 North Section St. Ward 1
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 yrs. 2 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 30 - 1840

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
88 10 20

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (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) Hannibal Mo.

10. NAME OF FATHER Adison Owen

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT (Address) Harry C. Owen
Hannibal Mo.

15. FILED 2/23 1929 E. Stone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 20 - 1929

17. I HEREBY CERTIFY That I attended deceased from 2 - 20 - 29 to 2 - 20 - 29 that I last saw him alive on 2 - 20 - 29 and that death occurred, on the date stated above, at 8:35 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Senility
131
162 (duration) yrs. mos. da.
 CONTRIBUTORY chronic nephritis (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) W. P. Brucey, M. D.
2-21-1929 (Address) Hannibal 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 Riverside Cemetery DATE OF BURIAL 2/22 1929

20. UNDERTAKER Schwartz Funeral Home ADDRESS Hannibal Mo.

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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