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

Do not use this space.

8242

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City S. Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 1891

15159

2. FULL NAME Albert Owens

(a) Residence. No. 2851 S. Jefferson St., 23 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17 - 1894

7. AGE: Years 34 | Months 5 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(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) Texas

PARENTS

10. NAME OF FATHER Abraham Owens

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

12. MAIDEN NAME OF MOTHER Ada Trivunger

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

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED ..... 19 ..... Max C. Stahlock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1929

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Feb 7, 1929, that I last saw him alive on Feb 7, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Stenosis
Card. Decompensation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 900 92 B

(duration) ..... yrs. 9 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) R. Berg M. D

2/8, 1929 (Address) City Hospital

*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: St Peter & Paul Cemetery

DATE OF BURIAL: 2/11 1929

20. UNDERTAKER: Walker Helderle

ADDRESS: 2331 S Bdwy

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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Oeverno.