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

Do not use this space.

32138

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9185

City St Louis (No. St Johns Hos St. ..... Ward)

2. FULL NAME Ethan A Owens

(a) Residence. No. 6728 Clayton St., 4 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	67			

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

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

PARENTS

10. NAME OF FATHER Ethan Owens

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

12. MAIDEN NAME OF MOTHER Marie King

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

14. INFORMANT Allan Owens
(Address) 6728 Clayton av

15. FILED SEP 13 1929 Max C Starkey REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1929, to Sept 12, 1929 that I last saw him alive on Sept 12, 1929, and that death occurred, on the date stated above, at 5:30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
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82A (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
(duration) 1 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W B Kieffer, M. D.

9/13, 1929 (Address) 4500 Olive St.

*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
Valhalla	Sept 16 1929

20. UNDERTAKER	ADDRESS
Harrigan & Sheahan Undg	4415 Washington

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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Omar Sevrer