MAR 25 1930

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

Do not use this space.

4398

1. PLACE OF DEATH
County Clay
Township Gallatin
City N.M.C. Mo. (No. ..... St. ..... Ward)
Registration District No. 197
Primary Registration District No. 5276
File No. .....
Registered No. 7

2. FULL NAME Clarence Owsley
(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 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) Feb. 3 - 1930

7. AGE

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

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

PARENTS
10. NAME OF FATHER Eugene Owsley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Rosa F. Stevenson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT Eugene Owsley
(Address) N.M.C. Mo. # 5

15. FILED 2/5, 1930 G R Dagg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4" 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 - 1930, to Feb. 4, 1930 that I last saw him alive on Feb. 4, 1930, and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
11B
11B
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Mother had Influenza at time of this birth (duration) ..... yrs. ..... mos. 7 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.C. Purviance, M. D.
, 19 (Address) Avondale 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 Providence
DATE OF BURIAL 2/5 1930

20. UNDERTAKER [illegible]
ADDRESS N.M.C. 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.