

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kearney
City Kansas City (No. Kansas City Gen Hosp)

Registration District No. 1002
Primary Registration District No. 1002

22946
File No. 2938
Registered No. 2938
St. _____ Ward _____

2. FULL NAME

Charles L. Owens

(a) Residence. No. 708 Tracy St. 1 Ward. _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 8 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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 3-1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
35 4 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work meat cutter
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) McPherson
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Sam Owens

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

12. MAIDEN NAME OF MOTHER Mary Johnson

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

14. INFORMANT Ye and Clerk
(Address) K. C. Genl Hosp.

15. FILED 7/16, 1930 M M Lowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-12 1930 to 7-15 1930
that I last saw him alive on 7-15 1930, and that death occurred, on the date stated above, at 12:15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation of Heart
95B

CONTRIBUTORY (SECONDARY)

90/10
(duration) yrs. _____ mos. _____ ds.
(duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes 7-16-30

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) P. E. Wilcox, M. D.

7-15 1930 (Address) Sub 7c. C. Gen. Hosp
*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

Forest Hill 7-17 1930

20. UNDERTAKER ADDRESS

O. V. Mast 8 Ems

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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