

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

Do not use this space.

30444

1. PLACE OF DEATH

County Cass
Township Bradford
City Lincoln Mo. (No. _____)

Registration District No. 448
Primary Registration District No. 5849

File No. _____
Registered No. 19
St. _____ Ward _____

2. FULL NAME

Barbara Ray Owens
(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. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 28-1933
7. AGE YEARS MONTHS DMS IF LESS than 1 day, _____ hrs. or _____ min.
19

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

9. BIRTHPLACE (CITY OR TOWN) Lincoln
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Thos Owens
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lincoln
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Anna McDaniel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Belle
(STATE OR COUNTRY) Mo

14. INFORMANT Thos Owens
(Address) Lincoln Mo.

15. FILED Sept 17, 1933 Mrs Dora Jett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 1933
17. I HEREBY CERTIFY, That I attended deceased from Sept 16 (3 AM) 1933, to Sept 16 (8 PM) 1933, that I last saw h. _____ alive on Sept 16, 1933, and that death occurred, on the date stated above, at 1:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure of Fœtal Circle to Close
1570 / 58 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ 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 _____
(Signed) J. C. Cooper M. D.
Sept 16 1933 (Address) Lincoln 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 Lincoln Mo DATE OF BURIAL 9-17 1933

20. UNDERTAKER Walter Gerlach ADDRESS Lincoln Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FILED OCT 20 1933

