

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

Do not use this space.

1. PLACE OF DEATH

County Vernon Registration District No. 878
 Township Northwell Primary Registration District No. 6157
 City (No. _____) St. _____ Ward _____

File No. 22921
 Registered No. _____

2. FULL NAME

Robert Owens
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)
 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lewida Owens
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 17 - 1855
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 3 2 12
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Teacher
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation all

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/5 - 1934
 22. I HEREBY CERTIFY, That I attended deceased from 6/5 - 1934 to 6/19 1934
 I last saw him alive on 6/6, 19____. Death is said to have occurred on the date stated above, at 9:00 m.
 The principal cause of death and related causes of importance were as follows:
Leigamias not putative
But probably carcinoma
of larynx
 Date of onset _____
 Other contributory causes of importance: 44

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 13. NAME John A. Owens
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 15. MAIDEN NAME Nancy Kusnick
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 17. INFORMANT John E. Owens
 (ADDRESS) Sheldon Ave
 18. BURIAL, CREMATION, OR REMOVAL PLACE Chase Branch DATE June 10 1934
 19. UNDERTAKER E. B. Benson & Son
 (ADDRESS) Sheldon Ave
 20. FILED June 10 1934 M. S. K. Knudsen
 Registrar.

Name of operation None Date of _____
 What test confirmed diagnosis? Micro Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Arthur G. Williams, M. D.
 (Address) Sheldon Ave

N. B.—Every item on this form 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.

JUL 9 1934

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JUL 16 1956

Vermon

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Robt Queen
Who died at Monteville, Mo on June 9 1894
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth Feb 17-1855 Age: Years 39 Months 3 Days 22

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

Signature of Registrar W. S. Kohendoffer

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 873 Very truly yours,
Primary Reg. Dist. No. 6157 E. T. McGaugh *md*
sc

Special Agent.

FNT RECORD

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