

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.

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

787
Do not use this space.

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
D. 14483 5.3.0
 2. PRINT FULL NAME Frank Owens
 (a) Residence, No. 1500 Pine St. 25 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) May 9, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 68 8 7

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. nil
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

FATHER
 13. NAME John Owens
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME Nellie ?
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT Hosp. Info. M. Kent (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem DATE Jan 25 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. H. Walker & Sons
224 1/2 Main St
 20. FILED Jan 25 1939 J. B. Beck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/16/39 1939

22. I HEREBY CERTIFY, That I attended deceased from 1:4/39 1939 to 1/16/39 1939
 I last saw him alive on 1/16/39 1939. Death is said to have occurred on the date stated above, at 11.10 a
 The principal cause of death and related causes of importance were as follows:
Carcinoma of stomach
 Date of onset

Other contributory causes of importance:
HBP

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? yes

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?.....
 If so, specify.....
 (Signed) J. H. Walker M. D.
 (Address) City Hospital No. 1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.