REC'D FEB 21 1939

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

1626
Do not use this space.

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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1. PLACE OF DEATH

(a) County Buchanan — Registration District No. 85

(b) Township — Primary Registration District No. 1001 — Registered No. 24

(c) City St. Josephm — (d) Street No. 613 N.17th. 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 71 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? 71 yrs. — mos. — ds.

2. PRINT FULL NAME 520 Mary Danckmeyer Owens

(a) Residence, No. 613 N.17th. St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 21,1849.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	89	9	17	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Luxenburg Germany 6

FATHER
13. NAME Michael Thinness 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany 6

MOTHER
15. MAIDEN NAME Anna K.Ruetter
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany

17. INFORMANT (ADDRESS) Mrs. Christina Sebus 613 N.17th. Str. St.Joseph,Mo.

18. BURIAL, CREMATION, OR REMOVAL Mt.Mora Cemetery
PLACE St.Joseph,Mo. DATE Jan.10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.O.Sidenfaden & Son 1802 Union Str.St.Joseph,Mo.

20. FILED 1-9 1939 H.J. Nesthuch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 8 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1939, to Jan. 8, 1939
I last saw her alive on Jan. 8, 1939. Death is said to have occurred on the date stated above, at 3:45 PM.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypostatic pneumonia	Jan 1-39
Other contributory causes of importance:	
General Arteriosclerosis	Unknown
Arteriosclerotic Heart Disease	

Name of operation None Date of
What test confirmed diagnosis? None 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) J. F. Chiarottino M. D.
(Address) 210 Kirkpatrick Bldg St Joseph Mo

(Licensed Embalmer's Statement on Reverse Side)

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, Elbert E. Harrington, or by **********

Registered Apprentice No. *******, working under my personal supervision.

Signed E E Harrington

Licensed Embalmer No. 3258,

P. O. Address 1802 Union Str. St. Jos

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

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