

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.

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

16630
 Do not use this space.

791
 1008

4164

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City..... (d) Street No. *Mo. Pacific Hospital* St. Registered No.
 (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. (If How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *527 CHAS. ELMORE OWENS*

(a) Residence, No. *1635 KNAPP ST.* St. *26*
 (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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Emma Sivens*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 13-1870*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *68 10 20*
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *yard man.*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Mo. Pacific*
 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) *St. Louis, Mo*

FATHER 13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

MOTHER 15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

17. INFORMANT (ADDRESS) *Catherine Moore 1633^a Knapp St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Widow's* DATE *May 6 1939*

19. FUNERAL DIRECTOR (ADDRESS) *Hy. Leidinger 1417 N. Market St.*

20. F. M. R. *MAY 4 1939* 19 *J. F. Beckwith* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 3 1939*

22. I HEREBY CERTIFY, That I attended deceased from *April 12 1939* to *May 3 1939*.
 I last saw him/her alive on *May 3 1939* Death is said to have occurred on the date stated above, at *5:28 P.m.*
 The principal cause of death and related causes of importance were as follows:

Decenerative Heart Disease
Cardiac Decompensation

Other contributory causes of importance:

Name of operation *None* Date of.....
 What test confirmed diagnosis?..... 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?.....
 If so, specify *Henry T. Durb*, M. D.
 (Signed) *Mo. Pac. Hosp*
 (Address)

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Homer L. Ponder
Licensed Embalmer No. 3367

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.)