

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.

REG SEP 12 1939
Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 659

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
210 E. DIVISION
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME MILTON HUGH OWINGS 520

8. (b) If veteran, name war NO 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHARLATT 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JUNE 28 1974
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

✓ 65	4	27	_____ hr. _____ min.
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9. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)

10. Usual occupation FOREMAN SPGD. TRACTION

11. Industry or business CO.

MOTHER FATHER { 12. Name ASO OWINGS

{ 13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

{ 14. Maiden name UNKNOWN

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Milton Owings
(b) Address 1222 St. Louis

17. (a) BURIAL (b) Date thereof 8-27-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crematorium

18. (a) Signature of funeral director John Wagner
(b) Address H. H. E. Co. 811 S. 1st St. Springfield

19. (a) 8-26-39 (b) Chas. C. Bergenthal
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GREENE

(c) City or town SPRINGFIELD MO
(If outside city or town limits, write "RURAL")

(d) Street No. 210 E. DIVISION ST
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year 1939 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from at various times from Jan 30, 1938, to Aug 25, 1939 that I last saw him alive on Aug 25, 1939 and that death occurred on the date and hour stated above

Immediate cause of death Valvular heart lesion Duration 3 mo.

Due to Breaking down of heart Valvular Lesion

Due due to toxemia

Other conditions Neurosis
(Include pregnancy within 3 months of death)

Major findings: None PHYSICIAN _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature S. F. Fremman (M. D. or other) _____
Address Springfield Date signed 8/27/39

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.....

J.B. Klingner & Ogle Sloan Jr. Registered Apprentice No. 732
working under my personal supervision.

Signed J.B. Klingner
Licensed Embalmer No. 3358
P. O. Address Spgd mo.

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.

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