DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40564

Registration District No. DEC 18 1939 763 Primary Registration District No. 4424 Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

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

(c) Name of hospital or institution: V (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) 500

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo 1 (b) County Polk

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

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME MARY ELLEN OWENS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband ~~or wife~~ Richard H. Owens

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 2 (Day) 1872 (Year)

8. AGE: Years 64 Months 11 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business 0

FATHER
12. Name Thomas Robertson
13. Birthplace (City, town, or county) Ind (State or foreign country)

MOTHER
14. Maiden name Harriett Myers
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Glen Owens

(b) Address Humansville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1939 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Joseph F. Firestone

(b) Address Humansville Mo.

19. (a) Dec. 7 1939 (Date received local registrar) Ora M. Rich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 1 year 1939 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from March 19, 1939, to December 1, 1939; that I last saw her alive on December 1, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia	2 days
Due to Carcinoma of face	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — 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? (Specify type of place)

While at work? (e) Means of injury

632

23. Signature H. H. Bowerman (M. D. [redacted]) 1

Address Humansville, Mo. Date signed 12-5-39

(Licensed Embalmer's Statement on Reverse Side)

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.

52

RECEIVED
District Health Officer No. 2
District File Number 7-39-16
Date Filed 12-11-39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Ralph A. Joseph

Licensed Embalmer No. 3149

P. O. Address Humansville

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

40564
Do not use this space.

1. PLACE OF DEATH
(a) County: Polk — Registration District No.: 703
(b) Township: — Primary Registration District No.: 4424 — Registered No.:
(c) City: Humansville (d) Street No.: , 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.

2. PRINT FULL NAME: Mary Ellen Owens
(a) Residence, No. 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): M

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
66	11	29	

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.
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)

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 1 1939

22. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19.
I last saw h alive on , 19. Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypostatic Pneumonia	
Carcinoma of face	
left cheek in front of left ear	

Other contributory causes of importance:

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

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) H. H. Bowerman M. D.
(Address) Humansville Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should