

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

42865
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 86
 (b) Township Washington Primary Registration District No. 5127
 (c) City Washington (d) Street No. Route # 6 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 37 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 C. M. Owen
 (a) Residence, No. Route # 6 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 21, 1867

7. AGE YEARS 72 MONTHS 7 DAYS 3 IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Carpenter
 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) Marietta (STATE OR COUNTRY) Ohio

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

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

17. INFORMANT (ADDRESS) Mrs. C. M. Owen
R. No. 6, same place as above.

18. BURIAL, CREMATION, OR REMOVAL PLACE King Hill Cem. DATE Dec. 26, 1939

19. FUNERAL DIRECTOR (NAME) Clark Mortuary (ADDRESS) 5025 King Hill Ave.

20. FILED Dec 26 1939 H. J. Neathel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/2, 1939, to 12/24, 1939.
 I last saw him alive on 12/15, 1939. Death is said to have occurred on the date stated above, at 12:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Cancer of Uterus Date of onset 12.58

Other contributory causes of importance:
Renal Arteriosclerosis

Name of operation None Date of
 What test confirmed diagnosis? See card Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury None, 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 None
 Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? Yes
 If so, specify Renal Arteriosclerosis M. D.
 (Signed) Wm. H. ...
 (Address) ...

Mr. Cook 2506 Lafayette

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~~ xxxx Dec. 24, 19

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

Signed: *Earl A. Cook*

Licensed Embalmer No. 3476

P. O. Address St. Joseph, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42865
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 86
(b) Township Washington Primary Registration District No. 5127 Registered No. 1318
(c) City..... (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

(a) Residence, No. Clark St. St. Owen
(Usual place of abode, if no street address, write county or city) St. (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) 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.
72 7 3

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 Dec 26 1939 A. Neelbauer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 24 1939

22. I HEREBY CERTIFY, That I attended deceased from

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

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) Emmett H. Couch, M. D.

(Address) St. Joseph

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

SUPPLEMENTARY

