

No. 2
11-10-39
17-39
K X2142

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14923**
Registrar's No. **385**

Registration District No. **1000 318**

Primary Registration District No. **2001**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: 2255 Pierce St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Several months years, months or days)

3. (a) PRINT FULL NAME CARRIE MAY OWERS

3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Thomas Owens 6. (c) Age of husband or wife if alive 57 1/2 years

7. Birth date of deceased April 7 - 1887
(Month) (Day) (Year)

8. AGE: Years 53 Months 15 Days _____ If less than one day hr. _____ min. _____

9. Birthplace Greene County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Practical Nursing

11. Industry or business Superior County Hospital

12. Name J. M. Sewell

13. Birthplace Greene Co Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Martha Manning

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

16. (a) Informant Mrs. M. A. Crocker

(b) Address 2255 Pierce St Springfield Mo
Pierce

17. (a) _____ (b) Date thereof April 24 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pleasant Cemetery

18. (a) Signature of funeral director Walter Brown

(b) Address Walnut Grove Mo.

19. (a) 4/24/40 (b) W. E. Haudley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2255 Pierce St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1940 hour 11 minute 40 p. M.

21. I hereby certify that I attended the deceased from 1-20-40
to 4/22/40 to 4/22/40 1940
that I last saw her alive on 4/15/40 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus primary
Duration _____

Due to C
Due to C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Fibroid uterus
Radic Carcinoma
Of autopsy no

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? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

9/11 _____ (Specify type of place)
While at work? no (e) Means of injury _____

23. Signature S. F. Freese (M. D. or other) _____
Address Springfield Mo Date signed 4/24/40

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 Genea Bonn

Licensed Embalmer No. 2664

P. O. Address Walnut Grove

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.

X