

Registration District No. 791

Primary Registration District No. 1003

5437

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1428 Locust 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 _____
years, months or days

3. (a) PRINT FULL NAME Dr. Robert E. Owen 500

3. (b) If veteran, name war World War 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased February 24 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 28 If less than one day
hr. min.

9. Birthplace Arlington Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor Of Medicine

11. Industry or business _____

12. Name John R. Owen

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

14. Maiden name Frances Ray

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

16. (a) Informant Robert E. Owen

(b) Address 1428 Locust St.

17. (a) Burial (b) Date thereof 6/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE Cemetery

18. (a) Signature of funeral director E. J. Schur

(b) Address E. J. Schur 3125 Lafayette

19. (a) JUN 24 1940 (b) J. F. Buddeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1428 Locust St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1940 hour 7:45 minute A M.

21. I hereby certify that I attended the deceased from Apr 4 1940 to June 22 1940
that I last saw h. alive on June 21 1940
and that death occurred on the date and hour stated above,
Immediate cause of death Coronary Disease Duration about 3 mo.

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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?

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

23. Signature E. J. Schur (M. D. or other) _____
Address 607 N. Grand 6/24/40 Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Just B. Vollmer

Licensed Embalmer No.

4014

P. O. Address

3185 Lafayette Ave.

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.