

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24747
Registrar's No. 223

Registration District No. 89

Primary Registration District No. 05131

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Papier Bluff Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bernard Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Examination
In this community At home Mo (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
(c) City or town Rambauer Mo
(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.? Native years.

3. (a) PRINT FULL NAME William Davis Owens

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

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

6. (b) Name of husband or wife allie la - Deceased 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Apr 14 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days 14 If less than one day hr. _____ min. _____

9. Birthplace Newport Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Angerlings Owens
13. Birthplace Huron Co Ky
(City, town, or county) (State or foreign country)

14. Maiden name Martha Ann Blaylock
15. Birthplace Newport Ky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W D Owens
(b) Address Rambauer Mo

17. (a) Owens Care (b) Date thereof 7-25-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rambauer Mo

18. (a) Signature of funeral director W Lloyd Russell
(b) Address High St St

19. (a) 7/24/40 (b) W D Owens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day July
year 1940 hour 12 minute 45 AM.

21. I hereby certify that I attended the deceased from July 6, 1940 to July 24, 1940;
that I last saw him live on July 6, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Malignancy, Multiple tumors
Due to involving brain and subcutaneous tissue
Due to tissue
(Refer to Bernard Hospital)
Other conditions (Include pregnancy within 3 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings: Of operations Tumors 50
Autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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) (e) Means of injury _____

23. Signature W Lloyd Russell (M. D. or other)
Address Papier Bluff Mo Date signed 7/24/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.