

No. 2  
13-40  
7-39  
X23159

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

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1206**

1. PLACE OF DEATH:

(a) County **BUCHANAN**

(b) City or town **ST. JOSEPH**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **STATE HOSPITAL No. 2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **24 days**  
(Specify whether years, months or days) **3**

In this community **24 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **2201 Hardesty**  
(If rural, give location)

(e) If foreign born, how long in U. S. A? **0** years.

3. (a) PRINT FULLNAME **Ethel Mary Owings**

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **16**  
year **1940** hour **5:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **October 22**, 1940, to **November 16**, 1940,  
that I last saw her alive on **November 16**, 1940,  
and that death occurred on the date and hour stated above.

4. Sex **F**

5. Color or race **W**

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

6. (b) Name of husband or wife **C. B. Owings**

6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **June 12 1902**  
(Month) (Day) (Year)

Immediate cause of death **Cancer**

Duration **4 yrs**

8. AGE: Years **38** Months **5** Days **4** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to **83**

9. Birthplace **Wellsville, Kansas**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **housewife**

Major findings: Of operations \_\_\_\_\_

11. Industry or business **none**

Of autopsy \_\_\_\_\_

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

12. Name **W. E. Shelton**

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

14. Maiden name **Carrie**

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

16. (a) Informant **C. B. Owings**

(b) Address **2201 Hardesty, Kansas City, Mo**

17. (a) **Removal** (b) Date thereof **11-17-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wellsville, Kansas**

18. (a) Signature of funeral director **Walter B. Bowman**

(b) Address **319 N. 10 St. Joseph, Mo**

22. If death was due to external causes, fill in the following: **no**

(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? **85**

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **A. N. Panthers** (M. D. another)

Address **State Hospital #2** Date signed **11/17/40**

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 11-16-

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Wm. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. 10th St. Joseph

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, fact should be so stated above.

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