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K23159

MOBILE FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

2216

State File No. ....

Registration District No. 183

Primary Registration District No. 4109

Registrar's No. 3

1. PLACE OF DEATH: Christian  
 (a) County Nixa  
 (b) City or town Nixa  
 (c) Name of hospital or institution: 1  
 (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 Robert Owens  
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced, widow  
 6. (b) Name of husband or wife Susan Owens 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Jan. 12 - 1852  
 (Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 25 If less than one day  
 hr. \_\_\_\_\_ min \_\_\_\_\_

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

10. Usual occupation merchant

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Robert Owens  
 13. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Susan Doras  
 15. Birthplace va Virginia  
 (City, town, or county) (State or foreign country)

16. (a) Informant Robert Owens  
 (b) Address Nixa, Mo

17. (a) Burial (b) Date thereof Jan. 8 - 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Payne Cem.

18. (a) Signature of funeral director J. W. Maples

(b) Address Clewer Mo

19. (a) Jan. 30, 1940 (b) Ida B. Hawkins  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Christian  
 (c) City or town Nixa  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7  
 year 1940 hour 9 minute 00 P.M.

21. I hereby certify that I attended the deceased from Jan. 6  
1941 to Jan 17, 1941;  
 that I last saw him alive on Jan 17, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Branchiopneumonia Duration 3 days

Due to Asphyxia slowly

Due to \_\_\_\_\_  
 Other conditions Smelly  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations X  
 Of autopsy X  
 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? \_\_\_\_\_  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
X

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

23. Signature W. A. Parsons (M. D. or other) D  
 Address Franklin Mo Date signed 1/8/41

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

RECEIVED

District Health Officer No. 6,

District File Number 241-301

Date Filed FEB 12 1949

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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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**