

Registration District No. 259

Primary Registration District No. 4127

Registrar's No. _____

1. PLACE OF DEATH:

(a) County DEKALB
(b) City or town MAYSVILLE MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 32 YRS. years, months or days

3. (a) PRINT FULL NAME JOHN BROOKS OWENS

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

4. Sex MALE 5. Color or race WHITE 6. (a) ~~Single, widowed, married~~ WIDOWED
6. (b) Name of husband or wife ETHEL B. OWENS 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased OCTOBER 16 1845 (Month) (Day) (Year)

8. AGE: Years 95 Months 5 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace CLINTON Co. MO (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business _____
12. Name JOHN B. OWENS
13. Birthplace TENN (City, town, or county) (State or foreign country)
14. Maiden name MARY THORP
15. Birthplace TENN. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Boone Owens
(b) Address Marysville MO

17. (a) BURIAL (b) Date thereof 4-6-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BERLIN MO. CEM.

18. (a) Signature of funeral director ROBERT FUNERAL HOME

(b) Address MAYSVILLE MO

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DEKALB
(c) City or town MAYSVILLE (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? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 5 year 1941 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 10, 30 _____, 1941, to apr 5 _____, 1941
that I last saw him alive on apr 4 _____, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death chronic suppurative Duration 2 yrs

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 _____

28. Signature [Signature] M. D. or other? _____
Address Marysville Mo Date signed 4/12/41

PHYSICIAN
Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

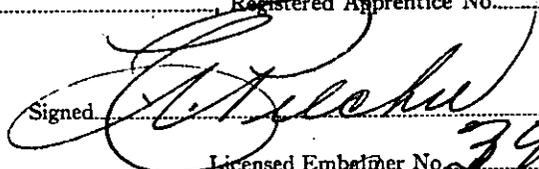
STATEMENT BY LICENSED EMBALMER

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.

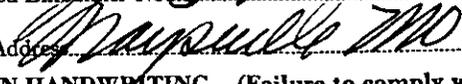
Signed.....



Licensed Embalmer No.....

3960

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.

FILLED JUL 17 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14397

Registration District No. 259

Primary Registration District No. 4158

Registrar's No.

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Maysville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(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 John Brooks Owen
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 95 Months 2 Days 19
If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-12-41 (b) Ethel H. Owen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH _____ month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____
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? _____

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

23. Signature R.P. Reynolds (M. D. or other)

Address Maysville Mo Date signed _____

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

SUPPLEMENTARY

S-14397