

FILED JUL 13 1942

Registration District No. 908

Primary Registration District No. 4549

State File No.

Registrar's No. 25

1. PLACE OF DEATH:
 (a) County WRIGHT
 (b) City or town WATER GLOVE
 (If outside city or town limits, write "RURAL" and name of township)
 (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)

2. USUAL RESIDENCE OF DECEASED: 114
 (a) State Mo (b) County WRIGHT
 (c) City or town WATER GLOVE
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country..... 0

3. (a) PRINT FULL NAME JOHN WILLIAM OWEN
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 16
 year 1942 hour 7:30 minute P. M.
 21. I hereby certify that I attended the deceased from.....
 that I last saw h..... alive on.....
 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced. 9
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased Oct 24 1858
 (Month) (Day) (Year)

Immediate cause of death.....
Cerebral Hemorrhage
 Due to Death was sudden
without medical aid
 Other conditions.....
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
83 6 22 hr. min.

Major findings:
 Of operations..... §30
 Of autopsy none
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

10. Usual occupation Farmer (Retired)
 11. Industry or business
 12. Name Daniel Owens
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 14. Maiden name Esther Owens
 15. Birthplace.....
 (City, town, or county) (State or foreign country)

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) Means of injury.....
 23. Signature F. O. Stiffe, coroner
 (M. D. or other)
 Address Manfield Blvd Date signed.....

16. (a) Informant Miss Edna Sanders
 (b) Address Wagonville, Mo
 17. (a) Burial (b) Date thereof 5-18-42
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Union Chapel
 18. (a) Signature of funeral director Geo. Stapp
 (b) Address Wagonville, Mo
 19. (a)..... (b).....
 (Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 6,

District File Number 742-1955

Date Filed JUL 11 1942

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

George Stapp
Licensed Embalmer No. 3161

P. O. Address W. H. Lane 77

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22559

Registration District No. 908

Primary Registration District No. 4549

Registrar's No.

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain Grove, 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

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 _____

3. (a) PRINT FULL NAME John William 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 _____

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

7. Birth date of deceased Oct 24 1883
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 13
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/15/42 (b) Ruby N. Perry
(City received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-22559