

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 9 1942

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3885

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3437 Park Ave. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 39 years  
years, months or 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. 3437 Park Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ross Dale Owen

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Ida M. Owen

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased February 26 1776  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 8 7 24 hr. min.

9. Birthplace Ft. Scott Kansas /  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Railway Mail Clerk

MOTHER FATHER { 12. Name Demetrius Owen

13. Birthplace Fayet Co. Indiana /  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah C. Milligan

15. Birthplace Hebron Ohio /  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida M. Owen

(b) Address 3437 Park Ave.

17. (a) Burial (b) Date thereof 10-22-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 10-21-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20  
year 1942 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 1  
1942 to Oct. 20, 1942  
that I last saw him alive on Oct 20, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Coronary disease with myocardial infarction

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 \_\_\_\_\_

23. Signature F. Chamar (M. D. or other) \_\_\_\_\_

Address 624 Professional Bldg Date signed Oct. 20

48  
38

Duration

1 d.

PHYSICIAN

Underline the cause to which death should be charged statistically.

361

11 44 26 1-4  
Lamon, R. H. B. B. B.  
Hullville, Va.

**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 Clarence H. Chiles  
Licensed Embalmer No. 3473  
P. O. Address 76 E Meo

**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.**