

RECEIVED JAN 11 1948  
Registration District No. ....

Primary Registration District No. 4162

Registrar's No. 41

1. PLACE OF DEATH:  
(a) County Daviess  
(b) City or town Locks Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Delivery-Locks Springs, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution .....  
(Specify whether  
In this community 66 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Daviess 31  
(c) City or town Locks Springs 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. General Delivery-Locks Springs  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Ada Josephine Owen

MEDICAL CERTIFICATION

3. (b) If veteran, name war None 3. (c) Social Security No. None

20. DATE OF DEATH: Month Dec. day 16th  
year 1942 hour 12:00 minute P.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife R. G. Owen 6. (c) Age of husband or wife if alive 25 years  
7. Birth date of deceased Aug. 25 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 21 1942 to 12-16 1942  
that I last saw him alive on 12-6-1942 and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 4 Days 21 If less than one day  
hr. min.

Immediate cause of death Myocardial Stevosis Duration Several years

9. Birthplace Livingston County-Missouri  
(City, town, or county) (State or foreign country)

Due to Acute Nephritis

10. Usual occupation House Wife

Due to .....

11. Industry or business .....

Other conditions (include pregnancy within 3 months of death) .....

MOTHER { 12. Name Thomas Boucher  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Gann  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings:  
Of operations .....

16. (a) Informant R. G. Owen  
(b) Address Locks Springs, Missouri  
17. (a) Pleasant Ridge (b) Date thereof 12-18-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) ✓  
(b) Date of occurrence .....

(c) Place: burial or cremation Pleasant Ridge Cemetery  
18. (a) Signature of funeral director H. B. Norman Co.  
(b) Address Chillicothe, Missouri  
19. (a) 12-18-1942 (b) H. O. Jackson  
(Date received local registrar) (Registrar's signature)

(c) Where did injury occur? .....

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

**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.....

E. R. Norman

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*E. R. Norman*

Licensed Embalmer No..... 2374

P. O. Address..... Chillicothe, Mo.

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 40624  
Registrar's No. 41

Registration District No. 98 Primary Registration District No. 4162

1. PLACE OF DEATH:

(a) County Wamesa  
(b) City or town Lack Springs  
(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 66 yrs years, months or days)

3. (a) PRINT FULL NAME Ada J. Owen  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race m 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 25 - 1876  
(Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name Thomas Baucher

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

14. Maiden name Baucher

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wamesa  
(c) City or town Lack Springs  
(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 Dec Day 25 Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I saw her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death mitral stenosis Duration 4 yrs  
Acute nephritis

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

Due to Possible Chronic Nephritis

Other conditions (I saw her about one week before she died)  
(Include pregnancy within 3 months of death)

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

Of autopsy 1014

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) Means of injury \_\_\_\_\_

23. Signature Raymond Barney (M. D. or other)  
Address Chelleoche Mo. Date signed 2/5-1943

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

SUPPLEMENTARY

