

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. ....

1. PLACE OF DEATH: *Laclede*  
 (a) County: *Laclede*  
 (b) City or town: *Lebanon*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: *Louis & Mallard Hospital*  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community: *6 da* (Specify whether)  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: *Mo.* (b) County: *Pulaski*  
 (c) City or town: *Crocker, Mo*  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.: \_\_\_\_\_ (If rural, give location) *rural*  
 (e) If foreign born, how long in U. S. A.? *1* years.

3. (a) PRINT FULL NAME: *Adelia Frances Owen*  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month *Dec* day *13*  
 year *1943* hour *12* minute *35* P. M.

4. Sex: *F* 5. Color or race: *W*  
 6. (a) Single, widowed, married, divorced: *married*  
 (b) Name of husband or wife: *C. M. Owen* 6. (c) Age of husband or wife if alive: *72* years  
 7. Birth date of deceased: *Nov 14 1856*  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Nov 7* 1942, to *Nov 13* 1942,  
 that I last saw her alive on *Nov 13* 1942,  
 and that death occurred on the date and hour stated above.

8. AGE: Years *87* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: *Myocardial insufficiency - chronic myocarditis*

9. Birthplace: *Chariton, Mo* (City, town, or county) (State or foreign country)

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

10. Usual occupation: *Housewife*

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

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

12. Name: *Wm. Riley* (City, town, or county) (State or foreign country)

Of autopsy: *no*

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

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

14. Maiden name: *Mary Brezger*

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

16. (a) Informant: *Mrs. Mary J. Gett*

(b) Address: *839 Nathan H. Chal*

17. (a) *Burial* (b) Date thereof: *12/15/43*  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Buchlin, Mo*

18. (a) Signature of funeral director: *J. L. Hoops, Son*

(b) Address: *Crocker, Mo*

19. (a) *Jan 31-43* (b) *Ernest Roper*  
 (Date received local registrar) (Registrar's signature)

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: *J*

23. Signature: *P. E. Howell* (M. D. or other) \_\_\_\_\_

Address: \_\_\_\_\_ Date signed: *12/15/43*

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

53  
1  
2

1070

Received .....  
Laclede County Health Unit  
File No. 12-43-190 .....  
Date Filed 7/17/48 .....

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 *Paul B. Hoop*.....

Licensed Embalmer No. 3261.....

P. O. Address *Cracker, Mo*.....

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.