S. No. 2
M—9-4-41
v. 5-17
PI X25360

FILED AUG 22 1944

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Doubler

State File No. 27772

Registration District No. ~~310~~ 128 Primary Registration District No. 2000 Registrar's No. 632

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

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burger Connelly Rest Home, 1030 Cherry
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Months (Specify whether years, months or days)
In this community 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield (If outside city or town limits, write "RURAL")
Street No. 1222 S. Delaware (If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Frank Owens
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Esther Owens
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased February (Month) 26 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 74	5	5	hr. min.

9. Birthplace Platte County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired
11. Industry or business Physician
MOTHER FATHER
12. Name M.P. Owens
13. Birthplace Platte County (City, town, or county) Missouri (State or foreign country)
14. Maiden name Elizabeth Dean
15. Birthplace Platte County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Esther Owens
(b) Address Springfield, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/2/44 (Month) (Day) (Year)
(c) Place: burial or cremation St. Joseph, Mo.
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 8-2-44 (Date received local registrar) (b) W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1 year 1944 hour 7:00 minute p. M.
21. I hereby certify that I attended the deceased from 1-1, 1943, to 8/1, 1944 that I last saw him alive on 7/31, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypo static pneumonia	24 days
Due to: Central Lemon Lage (Rt)	2½ yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): Cholelithiasis - Gastric Hemorrhages	
Major findings: Of operations X Of autopsy X	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature F. [illegible] (M. D. or other)
Address Springfield, Mo. Date signed 8/2/44

984 (Licensed Embalmer's Statement on Reverse Side)

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 Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield 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.