

S. No. 2  
M-9-4-41  
Rev. 5-17-39  
X29484

50621

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 314

Registration District No. 47 Primary Registration District No. 3008

4  
1  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Ocellular  
(b) City or town Fulton  
(c) Name of hospital or institution: State Hospital No 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 1 1/2 3 days  
(Specify whether years, months or days) same

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Pettis 14  
(c) City or town Sedalia  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 2  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_ 17

3. (a) PRINT FULL NAME JOHN OWENS  
3. (b) If veteran, name war D.K. 3. (c) Social Security No. D.K.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 18  
year 1944 hour 6 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Sept 1-1944  
to Sept 18 1944  
that I last saw him alive on Sept 18  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife D.K. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: April 3 1899  
(Month) (Day) (Year)

Immediate cause of death General Pseudo Infection  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 45 Months 5 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Alabama  
(City, town, or county) (State or foreign country)  
10. Usual occupation laborer

Other conditions Pulmonary Tuberculosis  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Charley Owens  
13. Birthplace Alabama  
(City, town, or county) (State or foreign country)  
14. Maiden name Esther Williams  
15. Birthplace Alabama  
(City, town, or county) (State or foreign country)

16. (a) Informant Revels  
(b) Address State Hospital No 1 Fulton  
17. (a) \_\_\_\_\_ (b) Date thereof Sept 21-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial Hospital Grounds  
18. (a) Signature of funeral director W. B. Thomas  
(b) Address 30 1/2 Market St. Fulton Mo.  
19. (a) 9-21-1944 (b) Josie Moseley  
(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 0  
23. Signature W. B. Thomas (M. D. or other) \_\_\_\_\_  
Address Fulton Mo Date signed 9-18-44

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-5-44

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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..**