

FILED NOV 20 1944
Registration District No. _____

Primary Registration District No. **1000**

Registrar's No. **1126**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Base Hospital, Rosecrans Field
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0** (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(c) State **Missouri** (b) County **Buchanan**
(c) City or town **St Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rosecrans Field**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Robert B. Owens**
3. (b) If veteran, **W.W.#2** name war **32 265 493**
3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **28**
year **1944** hour **2:30** minute **A.M.**
21. I hereby certify that I attended the deceased from **2:20 P.M.**
2:30 P.M. on Oct 28, 19**44**;
that I last saw him alive on **Oct 27**, 19**44**;
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **Nov. 3 1908**
(Month) (Day) (Year)

Immediate cause of death _____
Cardiac Failure
Duration **10 Min.**
Due to **Arrhythmia**
Due to **Ventricular Fibrillation**
Myocardial Ischemia
Other conditions (Include pregnancy within 3 months of death)
Major findings: **Q3d**
Of operations _____
Of autopsy **Myocardial Damage**
Cardiac Failure

8. AGE: Years Months Days If less than one day
35 11 25 hr. min.

9. Birthplace **Ellendale Del. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **U.S. Army**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace _____
14. Maiden name **Elenor Owens**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Post Records**
(b) Address **Rosecrans Field**

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?

17. (a) **Removal** (b) Date thereof **10-28-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ellendale, Del.**

18. (a) Signature of funeral director **Fleeman & Son Inc**
(b) Address **St Joseph, Missouri**

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Robert B. Owens** (M. D. or other)
Address **Station 409 St Joseph, Mo**

19. (a) **10-28-44** (b) **Helen J. Pickle**
(Date received local registrar) (Registrar's signature)

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

29 Oct 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, ~~by~~.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Robert Lytle

Licensed Embalmer No. 3308

P. O. Address. St. Joseph, 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.