

S. No. 2
DM-5-43
v. 5-17-39
I X36671

42129

State File No. _____
Registrar's No. 2587

FILED JAN 12 1945

Registration District No. 317

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Baden Station
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Halls Ferry Memorial Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Mary A. nes Owens

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Samuel Owens 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 9 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Cecil Owens

(b) Address 807a Clarendon

17. (a) Removal (b) Date thereof 12-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blytheville, Ark.

18. (a) Signature of funeral director Albert H. Hoppe,

(b) Address 4700 Washington Blvd.

19. (a) 12/19/44 (b) E. P. McWhirter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County Fulton
(c) City or town Hickman
(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 17
year 1944 hour 4:40 minute P. M.

21. I hereby certify that I attended the deceased from Dec 1st 1944 to Dec 17 1944
that I last saw him alive on Dec 17 1944
and that death occurred on the date and hour stated above

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Due to 830

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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)
(c) Means of injury _____
Signature Walter Shuman (M.D. or other)
Address 4832 - Maryland Date signed 12/19/44

FEB 20 1945

APR 5 1945

FEB 25 1945

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.....

G. W. Wilkinson
.....

Licensed Embalmer No.....

33-75

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.