. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

3546

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 367 Primary Registration District No. 3063 Registrar's No. 2854

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Almt 3 hours (Specify whether
In this community Life —
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 9 4 2

(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")

(d) Street No. 342 Attack
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Baby Girl Owens

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 73

5. Color or race Col

6. (a) Single, widowed, married, divorced S O

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 11 (Month) 1 (Day) 1944 (Year)

8. AGE: Years | Months | Days | If less than one day 3 hr. min.

9. Birthplace Clayton (City, town, or county) Missouri (State or foreign country) O

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Mathew Owens
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country) O

MOTHER
14. Maiden name Margaret Ewing
15. Birthplace Kirkwood (City, town, or county) Mo (State or foreign country) O

16. (a) Informant —
(b) Address —

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 1/23/45 (Date received local registrar) (b) E. G. McGovran (Registrar's signature) Chief

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1 year 1944 hour 9 15 minute A M.

21. I hereby certify that I attended the deceased from 11-1 1944 6 25 19 to 11-1- 1944 9 15 A M. that I last saw her alive on 11-1-1944 19 and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth (5 mos. gestation) — Duration Lived about 3 hrs.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 159

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?
(Specify type of place)

While at work? (e) Means of injury O

23. Signature J. A. Wilson, M.D. (M. D. or other)

Address 601 Brentwood Date signed 11/2/44

(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.....

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.