

No. 2
M-5443
7-5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3870

State File No. _____

FILED FEB 5 1945
Registration District No. 260

Primary Registration District No. 6225

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Wagon

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

(c) Name of hospital or institution:
State Hosp # 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 yrs 8 months
(Specify whether _____)

In this community Same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wade

(c) City or town Greenfield
(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 U

3. (a) PRINT FULL NAME Daniel Owen

3. (b) If veteran, name war None

3. (c) Social Security No. None

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 Oct 13 1875
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
year 1945 hour 12 minute 05 P.

21. I hereby certify that I attended the deceased from Nov 15, 1938, to Jan 31, 1945
that I last saw him alive on Jan 31, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

69 3 18 _____ hr. _____ min.

Immediate cause of death _____

Due to Hypertensive Cardiovascular

Due to Renal disease

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

9. Birthplace White Cloud, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Oscar C Owen

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

14. Maiden name Wancy Owen

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hoop Reed

(b) Address _____

17. (a) Removal
(Burial, cremation, or removal) (b) Date thereof Feb 2 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Lechwood, Mo

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Lechwood, Mo

19. (a) 1-31-45 (b) Hoazel B Dewick
(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 _____

23. Signature Thos J Greener (M. D. or other) _____

Address Wade Date signed 1-31-45

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

8000

1831

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Sanit Health Officer No. 71

License File Number 1-45-31

Date Filed 2-5-45

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. 1760

P. O. Address Nevada md

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.