

FILED APR 13 1945  
818

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
13 days

(d) Length of stay: In hospital or institution 13 days (Specify whether  
Life years, months or days)

3. (a) PRINT FULL NAME John Owens

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 493-09-1813

4. Sex m 5. Color or race col

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased June 25th 1895  
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Labor

11. Industry or business Semi Steel Casting Co

MOTHER FATHER { 12. Name John Owens

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

14. Maiden name Pearl unk

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

16. (a) Informant Mary Alice Owens

(b) Address 1436a North 15th Street

17. (a) burial (b) Date thereof 3-31-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J.H. Randle & Son

(b) Address 3133 Bell Ave

19. (a) MAR 23 1945 (Date received local registrar)

J. F. Breda (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 15

(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 25

(d) Street No. 1436 N. 15th (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26,  
year 1945 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from 13, 45 to March 26, 1945;  
that I last saw h im alive on March 26, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Rt. Lobar Pneumonia

Duration Indef.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature B. F. Murphy (M. D. or other) \_\_\_\_\_

Address 260 14th Street Date signed 3/26/45

**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 *J. J. Watson*  
Licensed Embalmer No. *2698*  
P. O. Address *2769 8 route*

**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.**