

FILED APR 10 1946

Registration District No. 96

Primary Registration District No. 4188

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Buffalo
(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 _____

3. (a) PRINT FULL NAME SAMUEL MILTON OWENS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced, married
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Jan 14 1873
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 21 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Oliver Owens

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

14. Maiden name _____

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

16. (a) Informant Mrs Sam Owens

(b) Address Buffalo Mo

17. (a) burial (b) Date thereof 3-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macedonia

18. (a) Signature of funeral director L B Jones

(b) Address Buffalo Mo

19. (a) 4-2-1946 (b) Oliver Owens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4
year 1946 hour _____ minute 15a M.

21. I hereby certify that I attended the deceased from 10 Sept 1946 to 3 March 1946
that I last saw him alive on 3 March 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 6 days

Due to Chronic nephritis 6 mos

Due to Hypertrophied prostate yes

Other conditions Pericious anemia yes
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 1318
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) _____ (e) Means of injury 0

23. Signature O. S. Griffin (M. D. or other) MD

Address Buffalo Date signed Apr 46

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

751-1111
District No. 3-46-365
District File No. 4-10-46
Date Filed

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 W. B. Jones
Licensed Embalmer No. 4322
P. O. Address Buffalo 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.