

FILED AUG 13 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 266

1. PLACE OF DEATH

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day (Specify whether
 In this community 20 yrs
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
 (c) City or town rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Postage Office
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bill 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. (b) Name of husband or wife Louise Owens 6. (c) Age of husband or wife if alive 28 years
 7. Birth date of deceased April 1 1909
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 3 16 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Owens
 13. Birthplace Unknown Tenn
 (City, town, or county) (State or foreign country)
 14. Maiden name Louise Russell
 15. Birthplace Unknown Kentucky
 (City, town, or county) (State or foreign country)

16. (a) Informant Louise Owens
 (b) Address Postageville Mo.

17. (a) Burial (b) Date thereof 7-19-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Postageville Cemetery

18. (a) Signature of funeral director Robert Funeral Parlor
 (b) Address Postageville Mo

19. (a) 8-6-1946 (b) G. G. Summers
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
 year 1946 hour 11 minute P M.

21. I hereby certify that I attended the deceased from 7-15-46 to 7-16-46
 that I last saw him alive on 7-16-46
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Intoxication Duration _____

Due to 1 - Bright's disease

Due to 2 - Renal Hypertension

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy ADDITIONAL SUPPLEMENTARY INFORMATION

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 _____

23. Signature Albert J. Estes (M. D. or other) MD
 Address Postageville Mo Date signed 7-24-46

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

Sanitary Health Officer No. 4

District File Number 846-2504

Date Filed 8-12-46

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

Leonard John Vargo

Licensed Embalmer No.

4336

P. O. Address

Postageville, 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.

Registration District No. 53 Primary Registration District No. 3010

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Bill Owens
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased April (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 38 Months 30 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____ Year 1956 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Chronic
Due to hepatitis
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 W W Prout (M. D. or other) _____
Address Altonville, Mo Date signed Aug 28 56

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

SUPPLEMENTARY

MOTHER FATHER

21796

82

10/10/10
10/10/10
10/10/10

22938