

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

**FILED NOV 26 1946**  
Registration District No. **200**

Primary Registration District No. **3041**

Registrar's No. **119**

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

**1. PLACE OF DEATH:** *Macon*

(a) County *Macon*

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

(c) Name of hospital or institution: *1*  
(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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State *Mo.* (b) County *Macon*

(c) City or town *Macon, Mo.*  
(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** *William 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 *Married*

6. (b) Name of husband or wife *Rachel Owens* 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *March 25 1862*  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<i>84</i>	<i>6</i>	<i>19</i>	hr. _____ min. _____

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

10. Usual occupation *Retired Farmer*

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name *W. Owens*

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

14. Maiden name *W.*

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

16. (a) Informant *Mr. Rachel Owens*

(b) Address *Macon, Mo.*

17. (a) Burial *Hopewell Cem*  
(Burial, cremation, or removal) (b) Date thereof *10-16-46*  
(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director *Stephus Goodding*

(b) Address *Macon, Mo.*

19. (a) *Nov 5-46* (b) *Ruth Mcneely*  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month *Oct.* day *14*  
year *46* hour *10* minute *30* P.M.

21. I hereby certify that I attended the deceased from *July 10 1946* to *Oct 14 1946*  
that I last saw him alive on *Oct 14 1946*  
and that death occurred on the date and hour stated above.

Immediate cause of death *Cerebral Arteriosclerosis* Duration *1 yr*

Due to *Cerebral Arteriosclerosis*

Due to *Senility*

Other conditions *✓*  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: *83A*

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (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 *[Signature]* (M. D. or other) \_\_\_\_\_  
Address *Macon* Date signed *10-14-46*

RECEIVED  
District Health Officer No. 10  
District File Number 20-46-2117-  
Filed NOV 25 1946

**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.