

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39844**

FILED DEC 28 1948

Registration District No. **128** Primary Registration District No. **2000** Registrar's No. **1103**

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:  
Burge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

In this community All of life  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Andrew Owings

3. (b) If veteran, name war No

3. (c) Social Security No. 487-28-7182

4. Sex M Color or race W

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

6. (b) Name of husband or wife Hattie

6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased August 2 1870  
(Month) (Day) (Year)

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

78 4 17 hr. min.

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

10. Usual occupation Ret. Cafe worker

11. Industry or business Ret. Cafe worker

MOTHER FATHER {

12. Name Unknown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant Ray Owings

(b) Address 2136 W. Chestnut

17. (a) burial (b) Date thereof 12-21-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) 12-21-48 (b) W. J. Audley, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Breene 39

(c) City or town Springfield  
(If outside city or town limits, write "RURAL") 6

(d) Street No. 2136 W. Chestnut  
(If rural, give location) 2

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19  
year 1948 hour 12 minute 40 a.m.

21. I hereby certify that I attended the deceased from 11-1-48  
\_\_\_\_\_ 19\_\_\_\_, to 12-19 -48 19\_\_\_\_;  
that I last saw him alive on 12-19-48 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration

Broncho-pneumonia 3 da

Due to Cardiac insufficiency mos.

Due to Arterio-sclerosis mos.

Other conditions annular carcinoma of  
(include pregnancy within 3 months of death) rectum 15 MOS

Major findings: \_\_\_\_\_

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 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. J. Audley, M.D.

Address 432 Medical Arts Date signed \_\_\_\_\_

DEC 29 1933

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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 *Max Rhodes*  
Licensed Embalmer No. *4071*  
P. O. Address *Springfield*

**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.**