

FILED AUG 8 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

35849

State File No.

BIRTH NO. _____ REG. DIST. NO. 353 PRIMARY REG. DIST. NO. 6196 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Sherrell</u>	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Sherrell</u>	d. STREET ADDRESS (If rural, give location) <u>East of Licking, Mo</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)
 a. (First) Ray b. (Middle) - c. (Last) OWEN d. DATE OF DEATH (Month) 7 (Day) 25 (Year) 1949

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Aug 23, 1893 9. AGE (In years last birthday) 55 UNDER 1 YEAR YEAR UNDER 1 MRS. MRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Agent 10b. KIND OF BUSINESS OR INDUSTRY L 11. BIRTHPLACE (State or foreign country) Licking Mo 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Burton Owen 13b. MOTHER'S MAIDEN NAME Eva Hayes 14. NAME OF HUSBAND OR WIFE Jane Owen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1st World War 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME Jane Owen ADDRESS Licking

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) apoplexy
 *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
 ANTECEDENT CAUSES (b) Nephritis Chronic
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (c) _____
 II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)
592X

19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) M 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1949, to July 25, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Lulu Randall (Degree or title) _____ 23b. ADDRESS Licking Mo 23c. DATE SIGNED July 26, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 7-27-49 24c. NAME OF CEMETERY OR CREMATORY Boone Creek Cem 24d. LOCATION (City, town, or county) (State) Texas Co Mo

DATE REC'D BY LOCAL REG. July 29, 1949 REGISTRAR'S SIGNATURE Mrs. E. Luora Neiser Smith 324 25. GENERAL DIRECTOR'S SIGNATURE Ferguson ADDRESS Licking Mo

(Licensed Embalmer's Statement on Reverse Side)

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

187
 3

Received
Repos
8-1-49
10:30

AUG 8 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Embert Ferguson

Student Embalmer _____

Student Embalmer

Licensed Embalmer No. _____

3945

P. O. Address _____

Licking 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.