

FILED DEC 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36823

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 163

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

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Washington, Mo)	c. LENGTH OF STAY (in this place) 2 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Rural (Central) Washington	
d. FULL NAME OF HOSPITAL OR INSTITUTION None Route #2		d. STREET ADDRESS (If rural, give location) R. #2	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) B. c. (Last) Owen	4. DATE OF DEATH (Month) 11 (Day) 26 (Year) 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-26-1876	9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months 2 IF UNDER 2 WRS. Days 2 Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (State or foreign country) Franklin Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jackson Owen	13b. MOTHER'S MAIDEN NAME Katherine Eveltzen	14. NAME OF HUSBAND OR WIFE Bertha willams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME Angela Eugene Donnell ms	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis, Chronic		INTERVAL BETWEEN ONSET AND DEATH 2 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4222

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 1948**, to **Nov. 26, 1949**, that I last saw the deceased alive on **Nov 23, 1949**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank R. Myers M.D.	23b. ADDRESS Washington, MO	23c. DATE SIGNED 11-28-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-29-1949	24c. NAME OF CEMETERY OR CREMATORY Reed Cemetery	24d. LOCATION (City, town, or county) (State) Franklin Co. Missouri
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DATE REC'D BY LOCAL REG Nov. 28, 1949	REGISTRAR'S SIGNATURE [Signature]	99	25. FEDERAL DIRECTOR'S SIGNATURE Pheroval Mitchell, St. Clair, ms	ADDRESS
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District File Number _____
RECEIVED DEC 3 1919
District Health Officer No. 9,

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.

Student _____
Student Embalmer

Signed _____

C. Jesse Gahr

Licensed Embalmer No. 4486

P. O. Address St. Clair, 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.