

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10496

State File No. 2915

FILED APR 9 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1005 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. 2119	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 907 N Leonard	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Will	b. (Middle)	c. (Last) Owens	4. DATE OF DEATH (Month) (Day) (Year) March 24 1951
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep. 3	8. DATE OF BIRTH Oct. 15, 1882	9. AGE (In years last birthday) 68	10. MONTHS	11. DAYS	12. HOURS	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Oklahoma	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Sam Owens	13b. MOTHER'S MAIDEN NAME Hannah ?	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St.	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Undet.
	ANTECEDENT CAUSES DUE TO (b) Undetermined		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None	

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H H 3 X

22. I hereby certify that I attended the deceased from 3-23rd, 1951, to 3-24th, 1951, that I last saw the deceased alive on 3-24, 1951, and that death occurred at 3:45p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Alvin J. Thompson, D.O.</i>	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 3-27-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>	24b. DATE MAR 29 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. MAR 29 1951	REGISTRAR'S SIGNATURE <i>J. B. Casater</i>	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

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.