

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22734

BIRTH NO. _____		REG. DIST. NO. <u>178</u>		PRIMARY REG. DIST. NO. <u>200</u>		Registrar's No. <u>748</u>		
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>SPRINGFIELD</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>D.O.A. ST. JOHN'S HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>1717 CHERRY</u> 02960				
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) _____ c. (Last) <u>OWEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 3 1954</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 26 1900</u>		9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Hours _____	IF UNDER 48 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGENT (INSURANCE)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRUDENTIAL LIFE CO.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>GALENA, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>CHARLES R. OWEN</u>			13b. MOTHER'S MAIDEN NAME <u>NELLIE HUTCHISON</u>		14. NAME OF HUSBAND OR WIFE <u>PAULINE OWEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. PAULINE OWEN SPRINGFIELD, MO.</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Vessel Disease</u> 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. _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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?				
22. I hereby certify that I attended the deceased from <u>Aug 3, 1954</u> , to <u>Aug 3, 1954</u> , that I last saw the deceased alive on <u>Aug 3, 1954</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>O.B. Horst M.D.</u>				23b. ADDRESS <u>430 South One Springfield Mr</u>		23c. DATE SIGNED <u>8/3/1954</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8/5/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NAPER PARK CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>			
DATE REC'D BY LOCAL REG. <u>8/6/54</u>		REGISTRAR'S SIGNATURE <u>Edith Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. H. LOHMEYER SPRINGFIELD, MO.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 17 1954

AUG 31 1954

APR 19 1955

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.....
Signature of Student Embalmer

Signed.....
William J. Swadlow

Licensed Embalmer No.....
421

P. O. Address.....
Spring

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.