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FILED SEP 21 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32315

BIRTH NO. 65349-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7876

0

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Incarnate Word Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dittmer
d. STREET ADDRESS (If rural, give location) RR #1

0500
1

3. NAME OF DECEASED (Type or Print)
a. (First) Jerry
b. (Middle) Antoine
c. (Last) Owen

4. DATE OF DEATH (Month) Aug (Day) 25 (Year) 56

5. SEX M 0
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N.M. 0
8. DATE OF BIRTH Aug 25-56
9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hrs.: Hours 3 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME David Crockett Owen
13b. MOTHER'S MAIDEN NAME Margaret Van Meter
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME David Crockett Owen
ADDRESS Dittmer Mo R#1

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature Birth
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Poly-hydramnios
27 wk Gestation

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 776.X
20. AUTOPSY? YES ☐ NO ☑

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) m.
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* 8-25-, 1956, *to* 8-25-, 1956, *that I last saw the deceased alive on* 8-25-, 1956, *and that death occurred at* 6:25 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) John B. Summers, M.D. 0
23b. ADDRESS 2264 S. Compton
23c. DATE SIGNED 8/25/56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 27-56
24c. NAME OF CEMETERY OR CREMATORY Grubville Bap. Cem.
24d. LOCATION (City, town, or county) (State) Grubville Mo.

DATE REC'D BY LOCAL REG. AUG 27 1956
REGISTRAR'S SIGNATURE J. Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Brimmer Funeral Home
ADDRESS House Springs Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 WAS NOT Embalmed, Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed John H. Brimmer

Licensed Embalmer No. 1470

P. O. Address Hawe Springs T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.