

FILED MAR 27 1958

THE DIVISION OF HEALTH OF MISSOURI 12450-58 58-012120
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1750

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1750

| | | | | | | | |
|---|---------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes# No <input type="checkbox"/> | | c. CITY OR TOWN St. Johns 4071 | | Inside Limits Yes# No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp. 1 Day | | | Length of stay in lb | | d. STREET ADDRESS (If outside, give location) 9024 North Ave. | | Reside on Farm Yes <input type="checkbox"/> No# |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Russell Owens | | | | 4. DATE OF DEATH Month Day Year Feb. 13, 1958 | | | |
| 5. SEX Male 0 | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED# WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 12, 1958 | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ##### | | 10b. KIND OF BUSINESS OR INDUSTRY ##### | | 11. BIRTHPLACE (City and state or country) St. Louis Mo. 0 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Earl R. Owens | | | | 14. MOTHER'S MAIDEN NAME Jacquelyn Muntz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Earl R. Owens 9024 North Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial anoxia respiratory failure intercranial anoxia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) intercranial anoxia DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 7730 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from 2-12-58 to 2-13-58 and last saw him alive on 2-7-58 Death occurred at 3:25 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Robert L. Korn M.D. | | | | 22b. ADDRESS 8230 Forsythe | | 22c. DATE SIGNED 2-13-58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 2/14/58 | 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann, Mo. | | | 25. DATE RECD. BY LOCAL REG. FEB 14 '58 | | 26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M. E. B. | | |

health, welfare, public service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

No Embalming

Signed *Sheldon Collier*

Licensed Embalmer No. *33*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.