

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH - 61-034770

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8113 STATE FILE NUMBER

FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY <u>City Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u> Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. # 1</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1315 N. 7th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First THOMAS Middle OWENS Last OWENS 4. DATE OF DEATH Month 8 Day 28 Year 61

5. SEX Male 6. COLOR OR RACE Colored 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH Aug 24 1915 9. AGE (last birthday) 46 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor 10b. KIND OF BUSINESS OR INDUSTRY Nashville, Tenn. 11. BIRTHPLACE (City and state or country) U.S.A. 12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME William Owens 13b. MOTHER'S MAIDEN NAME Jane Williams 14. NAME OF HUSBAND OR WIFE Emma Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 16. SOCIAL SECURITY NO. 17. INFORMANT Address Emma Owens 1315 N. 7th St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) PULMONARY PNEUMONIA - BACTERIAL DUE TO (c) CHRONIC BRONCHITIS 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) SLEEPING DISORDER - JESUAL PEPTIC ULCERS PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 5020

20c. TIME OF INJURY Hour Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  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 7-3-61 to 8-28-61 and last saw her/him alive on 8-28-61 Death occurred at 3:30am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T.E. Brittingham (degree or title) M.D. 22b. ADDRESS 1515 LAFAYETTE AVE. 22c. DATE SIGNED 8-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 9-1-61 23c. NAME OF CEMETERY OR CREMATORY National Cemetery Jefferson Barracks 23d. LOCATION (City, town, or county) JEFFERSON BARRACKS, MO (State)

24. FUNERAL DIRECTOR Estella S White ADDRESS 2616 N. Harrison Ave 25. DATE RECD. BY LOCAL REG. AUG 31 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5

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**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 John K. Birmingham

Licensed Embalmer No. 4476

P. O. Address 2405 Mar

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.