

FILE APR 12 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10289
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township _____ Primary Registration District No. 300
 (c) City St. Joseph, Mo. (d) Street No. State Hospital No. 2 Registered No. 370
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 9 yrs. 0 mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 500 Minnie Owen 3
 (a) Residence, No. State Hospital No. 2 St. Kahoka, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)
formerly Kahoka, Mo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb'y 27, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
59 1 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Chiropractor

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) March 21, 1931 11. Total time (years) spent in this occupation Unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kahoka, Missouri

FATHER 13. NAME William Owen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hedgesville, N.Y.

MOTHER 15. MAIDEN NAME Nancy Calkin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hamilton, Illinois

17. INFORMANT State Hospital Records
(ADDRESS) St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Kahoka, Mo. DATE April 2, 1940

19. FUNERAL DIRECTOR (NAME) Heaton, Beulah Bowen
(ADDRESS) 319 S. 10th. St. Fairport, Mo.

20. FILED April 9 1940 H. H. Nettles
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-31, 1940

22. I HEREBY CERTIFY, That I attended deceased from 7-15, 1939, to 3-31, 1940
 I last saw h. ex. alive on 3-31, 1940 Death is said to have occurred on the date stated above, at 6:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Chronic pulmonary tuberculosis
Tuberculosis laryngitis
Tuberculous cervical lymphadenitis

Date of onset
 ?
 ?
 ?

Other contributory causes of importance: 2 3
Cholelithiasis
Schizophrenia, paranoid type

Name of operation _____ Date of _____
 What test confirmed diagnosis? X-ray Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Sam Nelken M.D.
 (Address) State Hospital No. 2, St. Joseph, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

