

S. No. 2
11-10-35
7-5-17-35
I X 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33496**

NOV 16 1940 **791**

Registrar's No. **8193**

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ST. JOHNS HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 MO**
(Specify whether)
 In this community **LIFE**
years, months or days

3. (a) PRINT FULL NAME **JOHN OWENS**

8. (b) If veteran, name war **NONE** 8. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **JUNE 11 - 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	3	19	hr. _____ min. _____

9. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business **UNKNOWN**

MOTHER FATHER {
 12. Name " "
 13. Birthplace " "
(City, town, or county) (State or foreign country)
 14. Maiden name **UNKNOWN**
 15. Birthplace " "
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Dwyer**

(b) Address **2331 Grubbly St.**

17. (a) **BORIAL** (b) Date thereof **10-2-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY**

18. (a) Signature of funeral director **Huffman & Helled**

(b) Address **1416 N. Taylor Ave**

19. (a) **OCT 2 1940** (b) **J. B. ...**
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____
 (c) City or town **ST. LOUIS** **21**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3532 PABE**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **30**
 year **1940** hour **6** minute **P** M.

21. I hereby certify that I attended the deceased from **8-30-40** 19 to **9-30-40** 19;
 that I last saw him alive on **9-30-40** 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinomatosis, Primary site unknown**
 Duration **6 mo**

Due to _____
 Due to **53**
 Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
 Major findings: **Progn. metast. gland carcinoma**
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature **E. H. Bowdler** (M. D. or other) _____
 Address **Mo. Trust Bldg.** Date signed _____

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No.
working under my personal supervision.

City License
#145

Signed *Glenn E. Anderson*

Licensed Embalmer No. *4141*

P. O. Address *St. Louis Mo.*

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 this body is not embalmed, above space should be left blank.