

FILED SEP 12 1941

Registration District No. **113**

Primary Registration District No. **6018A**

Registrar's No. **127**

1. PLACE OF DEATH:

(a) County **St. Francois**
(b) City or town **Rural St. Francois Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **JAMES B. OWENS**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mary** 6. (c) Age of husband or wife if alive **Unknown** years
7. Birth date of deceased **Oct. 5 1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **10** Days **17** If less than one day hr. min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Night watchman for fire dept.**

11. Industry or business

MOTHER FATHER { 12. Name **Phillip Owens**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Cenn Feely**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **State Hospital No. 4 records**

(b) Address **Farmington, Mo.**

17. (a) **Burial** (b) Date thereof **8-25-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, Mo.**

18. (a) Signature of funeral director **Sullivan's**

(b) Address **St. Louis, Mo.**

19. (a) **Aug 24 41** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 95**
(c) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **4843 Maffit**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **22**
year **1941** hour **7** minute **P. M.**

21. I hereby certify that I attended the deceased from **8-12-41**, 19, to **8-22-41**, 19;
that I last saw him alive on **8-22-41**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Senile psychosis with terminal cerebral softening (apoplexy)** Duration **2 plus years**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **NO**
Of operations

Of autopsy **NO**

PHYSICIAN

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) (c) Means of injury

23. Signature **G. TIVIS GRAVES, JR., M. D.** (M. D. or other) **[Signature]**

Address **FARMINGTON MO.** Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 22 1941

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.

Signed *Albert Mayfield*

Licensed Embalmer No. *3077*

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, fact should be so stated above.