

12844

S. No. 2  
M-9-4-41  
5-17-39  
PI X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 10 1943  
Registration District No. 285

Primary Registration District No. 3039

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Dinn

(b) City or town Marceline  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 39 years

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dinn

(c) City or town Marceline  
(If outside city or town limits, write "RURAL")

(d) Street No. n. Missouri  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jennie Owens

3. (b) If veteran name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28  
year 1943 hour 2 minute 35 A.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife pg Owens

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Aug 28 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on Dec 26, 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 4 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Hemorrhage

Due to Dissecting Aneurysm

9. Birthplace Barton Maryland  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Robert C Pollock

13. Birthplace Scotland  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Sinclair

15. Birthplace Scotland  
(City, town, or county) (State or foreign country)

16. (a) Informant John Owens

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Dec 31 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Killiard

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? \_\_\_\_\_

18. (a) Signature of funeral director James M Laughlin

(b) Address Marceline Mo

19. (a) 12/30/43 (b) J.P. Patrick  
(Date received local registrar) (Registrar's signature)

23. Signature J.P. Patrick (M.D. or other) \_\_\_\_\_  
Address Marceline Mo Date 12/30/43

(Licensed Embalmer's Statement on Reverse Side)

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

18  
2  
1

13050

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

Signed *Blanche M Langhler*  
Licensed Embalmer No. *1909*  
P. O. Address *Marselina M*

**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.**