DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41504

Registration District No. 156 Primary Registration District No. 2001 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin (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 25 yrs (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Webb City 6 (If outside city or town limits, write "RURAL")

(d) Street No. 1001 N. Devon Str (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Althea Fern Owens

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

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

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 18 (Day) 1899 (Year)

8. AGE: Years 46 Months 8 Days 29 If less than one day hr. min.

9. Birthplace Shell Knob (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Barton M. Roberts
13. Birthplace (City, town, or county) Tex (State or foreign country)

MOTHER
14. Maiden name Melissa Jeffries
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Butler Owens

(b) Address Webb City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec (Month) 10 (Day) 1945 (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Webb City Und. Co.

(b) Address

19. (a) 12-11-45 (Date received local registrar) (b) Ed D Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 8 year 1945 hour 10 minute 25 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Thyroid crisis	24 hrs.
Due to: Thyroidectomy	
Due to: Thyrotoxicosis - severe	2 yrs.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

638

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) M.D.

Address Joplin, Mo. Date signed 12-8-45

140K

(Licensed Embalmer's Statement on Reverse Side)

45-12-965

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 A. L. Mills

Licensed Embalmer No. 347

P. O. Address Nutt City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.