

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED NOV 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 171

Primary Registration District No. 4302

Registrar's No. 133

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chula
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 46 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 59
(c) City or town Chula (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? NO. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME

Omar J. Owen.

3. (b) If veteran, name war ✓

3. (c) Social Security

No. 493-18-5064

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Eva Lee Owen

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July (Month)

9 (Day)

1879 (Year)

8. AGE:

Years

Months

Days

If less than one day

67

3

24

hr. _____ min.

9. Birthplace

Linn County
(City, town, or county)

Missouri
(State or foreign country)

10. Usual occupation

Retired Salesman

11. Industry or business

MOTHER FATHER

12. Name

James H. Owen

13. Birthplace

Kentucky
(City, town, or county)

1
(State or foreign country)

14. Maiden name

Sarah Ellen Kennedy

15. Birthplace

Kentucky
(City, town, or county)

1
(State or foreign country)

16. (a) Informant

Mrs J. S. Owen

(b) Address

Chula Mo.

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Nov 3 1946
(Month) (Day) (Year)

(c) Place: burial or cremation

Plainview

18. (a) Signature of funeral director

E. J. Robertson Funeral Home.

(b) Address

Chula Mo.

19. (a)

Nov 13 1946
(Date received local registrar)

(b)

Frances B. Neill
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

Nov day 3

year 1946

hour 3

minute A M.

21. I hereby certify that I attended the deceased from

March 1946 to 3 Nov. 1946

that I last saw him in alive on 3 Nov. 1946
and that death occurred on the date and hour stated above.

Immediate cause of death

Congestive Heart Failure

Duration

1 yr.

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Q3E

Of autopsy

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) no

(b) Date of occurrence none

(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

J. D. Wadswa

(M. D. or other) _____

Address Chillicothe Mo

Date signed 3 Nov 1946

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

36488

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 John M Robertson
Licensed Embalmer No. 4388
P. O. Address Laredo 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.