

S. No. 2
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5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11857
State File No. _____
Registrar's No. 804

Registration District No. 312 Primary Registration District No. 3070

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Webster College
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2-years
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sister Mary Jean Owings
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.O.
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 16th., 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 8 17 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Religious Teacher

11. Industry or business _____

MOTHER FATHER { 12. Name Zebulan Owings
13. Birthplace Alton Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Agnes Ring
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Matthew Marie
(b) Address Webster College

17. (a) Burial (b) Date thereof 4-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly
3840 Lindell Blvd.

(b) Address _____
19. (a) 4-7-47 (b) Lee J. Z...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Webster Groes
(If outside city or town limits, write "RURAL")
(d) Street No. Webster College
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr 3 day 1947.
year _____ hour _____ minute 9:50 M.
21. I hereby certify that I attended the deceased from Nov. 9 1944
19 _____ to Apr 3 19 47
that I last saw him alive on Apr 2 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death
Adeno-carcinoma of Colon
metastases of liver
and abdominal lymph
glands
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
3 1/2
a few minutes

Major findings: Carcinoma of Colon
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:
(c) 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 _____
Signature H. Victor Reese (M.D. or other) _____
Address 120 G. Lockwood Date signed 4/13/47

(Licensed Embalmer's Statement on Reverse Side) Webster Groves

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.

Signed Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address. 3840 Hindell

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.