

No. 2  
-12-45  
-17-39  
X47970

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JAN 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41852  
Registrar's No. 5465

Registration District No. 177

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution: GENERAL HOSPITAL NO. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 HRS. - 15 MINS.  
(Specify whether in this community 31 YRS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL.")

(d) Street No. 2420 PARK  
(If rural, give location)

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

3. (a) PRINT FULL NAME JAMES HASKELL OWENS

3. (b) If veteran, name war World War I

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 23, year 1947 hour 3: minute 00 P. M.

21. I hereby certify that I attended the deceased from DECEMBER 23, 1947, to DECEMBER 23, 1947, that I last saw him IM alive on DECEMBER 23, 1947, and that death occurred on the date and hour stated above.

4. Sex MALE 2

5. Color or race NEGRO

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

6. (b) Name of husband or wife MARJORIE OWENS

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased DECEMBER 27, 1896  
(Month) (Day) (Year)

Immediate cause of death BILATERAL LOBAR PNEUMONIA  
BILATERAL EXTENSIVE BRONCHIECTASIS  
BILATERAL GANGRENE OF LUNG

Duration

8. AGE: Years 50 Months 11 Days 26  
If less than one day hr. min.

9. Birthplace TAHLEQUAH OKLAHOMA  
(City, town, or county) (State or foreign country)

10. Usual occupation POLICE OFFICER

11. Industry or business

12. Name CHAPEL OWENS

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

14. Maiden name MOLLIE DAWSON

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

16. (a) Informant ZEPORA FRANKS (SISTER)

(b) Address 2420 PARK

17. (a) Burial (b) Date thereof 12/27/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director

(b) Address 1739 Lyda Ave.

19. (a) 12-27-47 (b) Etheldine Holms  
(Date received local registrar) (Registrar's signature)

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1.08

Of autopsy SAME AS ABOVE

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) (e) Means of injury

23. Signature (M. D. or other) M.D.  
Address GENERAL HOSPITAL NO. 2 Date signed 12/24/47

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.....

*Bruce Kelly*....., Registered Apprentice No. *511*  
working under my personal supervision.

Signed.....

*J J Maulou*  
Licensed Embalmer No. *3894*

P. O. Address. *2503 Highland*

**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.**