

FILED JUN 28 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

21209

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5448

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St Louis Childrens Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days
 (Specify whether
 In this community 3 yrs 1 mo 1 day
 years, months or days)

3. (a) PRINT FULL NAME Charles Oliver Owens3. (b) If veteran,
name war no3. (c) Social Security No.
none4. Sex male 5. Color or race white 6. (a) Single, widowed, married,
divorced single6. (b) Name of husband or wife none 6. (c) Age of husband or wife if
alive years7. Birth date of deceased May 14th 1945
(Month) (Day) (Year)8. AGE: Years 3 Months 1 Days 1 If less than one day
hr. min.9. Birthplace St Louis Mo.
(City, town, or county) (State or foreign country)10. Usual occupation child11. Industry or business none12. Name Benjamin F. Owens Jr.13. Birthplace E St Louis, Ills.
(City, town, or county) (State or foreign country)14. Maiden name Marion Maher15. Birthplace Lake Linden, Mich
(City, town, or county) (State or foreign country)16. (a) Informant Benjamin F. Owens Jr.
(b) Address Caseyville, Ills.17. (a) removal (b) Date thereof 6/1/48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Caseyville18. (a) Signature of funeral director Thomas M. Shupp(b) Address Collinsville, Ills.19. (a) JUN 15 1948 (b) J. F. Briscoe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Ills., St Clair 999
 (a) State (b) County
 (c) City or town Caseyville 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. none 0
 (If rural, give location) N.R. 2
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15th
year 1948 hour 10:21 minute A.21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital heart disease; ^{Duration}
Nitrous oxide ether anesthesia
while undergoing operation for con-
genital heart, at St. Louis Childrens
Hospital, on June 15, 1948, at 10:21
A.M.

Due to HOSP.Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 (c) Means of injury
 23. Signature J. F. Briscoe (M. D. or other)
 Address 1300 Olive St Date signed 6/15/48

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..... *George W. Debnick*

Licensed Embalmer No..... *1598*

P. O. Address.....

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.