

No. 2
-147
-17-39

State File No.

National Office of Vital Statistics
FILED NOV 3 1948

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 141

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

1. PLACE OF DEATH:

(a) County COOPER

(b) City or town BOONVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St Louis

(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4367 ENIGHT
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Owens, Mrs Malachi Alberta

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex ♀ 5. Color or race Negro

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

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

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

7. Birth date of deceased Dec 29, 1906
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1948 hour 8:20 minute 7 M.

21. I hereby certify that I attended the deceased from 5:30 PM
Oct 11 1948 to 8:20 PM Oct 11 1948
that I last saw him EV alive on Oct 11 1948
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

41 9 12 hr. min.

Immediate cause of death

Bulbar brain contusion 4 hrs

Basal skull fracture 4 hrs

Due to.....

Due to.....

Other conditions Fracture of mandible 4 hrs
(includes pregnancy within 3 months of death)

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

10. Usual occupation Housewife

PHYSICIAN

Major findings:
Of operations.....

Of autopsy Above

Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name John Keane

13. Birthplace St. Louis, MO
(City, town, or county) (State or foreign country)

14. Maiden name Alma Reed

15. Birthplace St Louis, MO
(City, town, or county) (State or foreign country)

16. (a) Informant Pinkie Bryant

(b) Address 6163 Bertha Ave St. Louis, MO

17. (a) Burial (b) Date thereof 10-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Musick Cemetery

18. (a) Signature of funeral director A. L. Bealville

(b) Address 4303 Delany Blvd

19. (a) 10-16-48 (b) D. Cooper
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide (specify) Accident - 27

(b) Date of occurrence Oct 11, 1948

(c) Where did injury occur? W Highway 40 west of B
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway
(Specify type of place)

While at work? No. (e) Means of injury auto wreck

23. Signature Malachi Owens (M. D. or other) MD

Address Boonville, Mo Date signed Oct 11, 1948

non-call Oct 11, 1948

RECEIVED 08 AON

District Health Officer No. 8,

District File Number _____

Date Filed 11-7-48

0701 & AON

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

Theodore J. Gandel

Licensed Embalmer No. 4243

P. O. Address Webster Avenue

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. novRegistration District No. 42Primary Registration District No. 3017Registrar's No. 141

1. PLACE OF DEATH:

- (a) County Cooper
 (b) City or town Boonville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days3. (a) PRINT FULL NAME Mrs. Alberta Owens

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased
- see 29
-
- (Month) (Day) (Year)

8. AGE: Years
- 41
- Months
- 9
- Days _____ (Unless than one day) _____ hr. _____ min.

9. Birthplace _____
-
- (City, town, or county) (State or foreign country)
- Mo

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 12. Name _____
 { 13. Birthplace _____ (City, town, or county) (State or foreign country)
 { 14. Maiden name _____
 { 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")

- (d) Street No. _____
-
- (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Nov
- year
- 1948
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

Due to _____

Due to _____

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 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) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-32921