

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5800

FILED JUL 18 1950

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis.	
b. CITY OR TOWN St. Louis, Mo	c. LENGTH OF STAY (in this place) 5 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN East St Louis Ill (burial)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Philips		d. STREET ADDRESS (If rural, give location) Goode Ave. 4090	

3. NAME OF DECEASED (Type or Print) Robert Owens	a. (First)	b. (Middle)	c. (Last) Owens	4. DATE OF DEATH (Month) (Day) (Year) July 2--1950
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5. SEX M	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Sept 1, 1908	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2 Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Memphis, Tenn;	12. CITIZEN OF WHAT COUNTRY? yes
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13a. FATHER'S NAME John Wesley Owens	13b. MOTHER'S MAIDEN NAME Lonnie Morgan	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 4194-24-8667	17. INFORMANT'S SIGNATURE OR NAME Gertie Owens	ADDRESS 104 Courtland Place
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) B. bronch. Pneumonia (virus)		
	DUE TO (c) Virus Pneumonia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H92X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:35 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 7/3/50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-3-50	24c. NAME OF CEMETERY OR CREMATORY Douglass	24d. LOCATION (City, town, or county) (State) East St Louis, Ill
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DATE REC'D BY LOCAL REG. JUL 5 1950	REGISTRAR'S SIGNATURE J B Sarater	25. FUNERAL DIRECTOR'S SIGNATURE Officer Funeral Home	ADDRESS 2114 No An
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John R. Cunningham

Licensed Embalmer No. _____

4476

P. O. Address _____

4107 Finney Ave

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.