S. No. 300
v. 10.48

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38899

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9522

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place): 103 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis Childrens

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orient 8120
d. STREET ADDRESS (If rural, give location): 8

3. NAME OF DECEASED (Type or Print)
a. (First): Russell
b. (Middle): Jess
c. (Last): Owsley

4. DATE OF DEATH (Month) (Day) (Year): Nov. 8 1950

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 1 - 1950
9. AGE (In years last birthday): If under 1 year: Months 4, Days 7; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Orient, Ill.
12. CITIZEN OF WHAT COUNTRY?: Amer.

13a. FATHER'S NAME: Richard Owsley
13b. MOTHER'S MAIDEN NAME: Roberta Tuck
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Richard Owsley, Orient, Ill. ADDRESS

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hydrocephalus
ANTECEDENT CAUSES: Hypopara thyroidism
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS: Convulsive seizure
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 271.1

22. *I hereby certify that I attended the deceased from* 7-29, 1950 *to* 11-8, 1950 *that I last saw the deceased alive on* 11-8, 1950 *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Don L. Thurston Md.
23b. ADDRESS: Childrens Hosp
23c. DATE SIGNED: 11-8-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 5
24b. DATE: 11-9-50
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): West Frankfort, Ill.

DATE REC'D BY LOCAL REG.: NOV 9 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed William S. Salfen

Signed _____
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, Mo.

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.