

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10402**
1950

MAR 24 1952

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2249	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 24 2749 Keokuk St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) ALEXANDER		b. (Middle)		c. (Last) OWEN		4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 1952		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 6, 1879	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optometrist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Texas	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Udocius Owen	13b. MOTHER'S MAIDEN NAME Unknown Thomas	14. NAME OF HUSBAND OR WIFE Amy Owen
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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.	17. INFORMANT'S SIGNATURE OR NAME Amy Owen 2749 Keokuk St.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis		
DUE TO (c)		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 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 332x
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22. I hereby certify that I attended the deceased from **1952**, to **2-28-1952**, that I last saw the deceased alive on **2-28-1952**, and that death occurred at **9:20 Am.**, from the causes and on the date stated above.

23a. SIGNATURE Charles E. Owen	(Degree or title)	23b. ADDRESS Sumner Bldg	23c. DATE SIGNED 2-29-52
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Mar. 1, 1952	24c. NAME OF CEMETERY OR CREMATORY Sunset Bural	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo
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DATE REC'D BY LOCAL REG. FEB 29 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	ADDRESS 4228 S. Kingshighway Bl
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

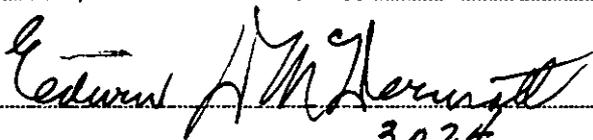
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 3024

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.