

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45483**

85-077
FILED FEB 2 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0421**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 2733 Stoddard	
3. NAME OF DECEASED (Type or Print) a. (First) Byron b. (Middle) c. (Last) Owens		4. DATE OF DEATH (Month) (Day) (Year) Dec. 19 1953	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH Oct. 31, 1953
9. AGE (In years last birthday) 7 wks		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? ****		13a. FATHER'S NAME George Owens	
13b. MOTHER'S MAIDEN NAME Ella Mae Owens		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records 2601 Whittier	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diarrhea (etiology undetermined)		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) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 5710			
22. I hereby certify that I attended the deceased from 12-12 , 19 53 to 12-19 , 19 53 , that I last saw the deceased alive on 12-19 , 19 53 , and that death occurred at 9:15 p m. , from the causes and on the date stated above.			
23a. SIGNATURE Homer Nash (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St.	
23c. DATE SIGNED 1-6-54			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-30-54	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JAN 15 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service	
REGISTRAR'S SIGNATURE J. Carl Smith MD		4104 Maplehurst Ave. St. Louis 10, Mo.	

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.