

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016128

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1138

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood 22,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood 4713</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>410 Crest Ave.</b>	Length of stay in 1b <b>3 yrs</b>	d. STREET ADDRESS <b>410 Crest Ave.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>STANNARD</b> Last <b>OWEN</b>			4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1895</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____	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) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>National Lead</b>	11. BIRTHPLACE (City and state or country) <b>St. Charles, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Austin Owen</b>	13b. MOTHER'S MAIDEN NAME <b>Rebecca Stannard</b>	14. NAME OF HUSBAND OR WIFE <b>Harriet M. Owen</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or type of service) <b>Yes - WW1 Navy</b>	16. SOCIAL SECURITY NO. <b>493-07-3858</b>	17. INFORMANT <b>Harriet M. Owen-410 Crest Ave. Mo.</b>	Address <b>Kirkwood 22</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Meningitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	<b>1621</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Obstructed Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Obstructed Emphysema</b>
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
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21. I attended the deceased from Death occurred at <b>8/15</b> to <b>4/25/59</b> and last saw him alive on <b>4/25/59</b> _____ on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Charles R. Brumfield M.D.</b>	22b. ADDRESS <b>206 W. Argonne Heights</b>	22c. DATE SIGNED <b>4/27/59</b>
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23a. BURIAL, CREMATION, or other disposition (Specify) <b>Removal</b>	23b. DATE <b>April 28, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cem.</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>	(State) _____
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24. FUNERAL DIRECTOR <b>Pfzinger Mort-Kirkwood 22, Mo.</b>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <b>4-27-59</b>	REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Ben E. Adams*

Licensed Embalmer No. *436*

P. O. Address *Adams*

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.