

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003947

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **379**

STATE FILE NUMBER

FILED JAN 17 1963		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 7b 50 YRS		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4432A West Bell Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Owens Last Owens			4. DATE OF DEATH Month 1 Day 12 Year 63		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1889	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House man		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and state or country) OKOLONA MISS	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME WILLIS OWENS		13b. MOTHER'S MAIDEN NAME CAROLINE	
14. NAME OF HUSBAND OR WIFE DECEASED		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO			
17. INDEMNITY Address 9 Sally Ward 4432nd W. BELLE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction Carcinomatosis of Colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 153.8 DUE TO (c) 153.8 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Anemia PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1-9-63 to 1-12-63 and last saw him ^{her} alive on 1-12-63 Death occurred at 3:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. H. Richards M.D.</i>		(Degree or title)		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 1-12-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			
23b. DATE 1-17-63		23c. NAME OF CEMETERY OR CREMATORY OAKDALE		23d. LOCATION (City, town, or county) (State) St. Louis 40 Co. MO	
24. FUNERAL DIRECTOR PRICE UND.CO 2829 Washington		ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 14 1963	
25. REGISTRAR'S SIGNATURE <i>Roan Smith M.D.</i>					

VS 300 Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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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 *Charles P. Flynn*

Licensed Embalmer No. 4444
P. O. Address: St Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.