

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026734

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1970

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 1 1963

VS 300  
Rev. 4/59

1 4015

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ballwin</b>		Length of stay in 1b <b>1 1/2 years</b>		c. CITY OR TOWN <b>Fenton</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>Pine Crest Home #1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>38 Boliford Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM L. OWENS</b>			4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/27/88</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Wm. Owens</b>			
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Eva Owens, Dec'd.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Jesse Owens, R.R. 1, Box 598, Fenton, Mo.</b>	
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>CHRONIC MYOCARDITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>&gt;</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROSIS</b>					<b>&gt;</b>
DUE TO (c) <b>SENILITY</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>AMPUTATED LEGS</b>				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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		Month, Day, Year			
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 <b>APRIL 30, 1963</b> to <b>JUNE 18, 1963</b> and last saw <sup>her</sup> him alive on <b>JUNE 18, 1963</b> Death occurred at <b>7:00A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>B.R. Lovins, M.D.</b>		22b. ADDRESS <b>BALLWIN, Mo.</b>		22c. DATE SIGNED <b>6-18-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>5/20/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		23e. REGISTRAR'S SIGNATURE <b>[Signature]</b>		23f. DATE RECD BY LOCAL REG. <b>6/19/63</b>	
24. FUNERAL DIRECTOR <b>Bopp Chapel, Kirkwood, Mo.</b>		25. DATE RECD BY LOCAL REG. <b>6/19/63</b>			

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**STATEMENT BY LICENSED EMBALMER**

0-28

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 Francis J. Highland Jr

Licensed Embalmer No. 4512

P. O. Address Richwood, 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.