

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29-38-1

1 PLACE OF DEATH
County Scotland
Township Thomson
or
Village Arbela
or
City

Registration District No. 808 File No. _____
Primary Registration District No. 5848 Registered No. _____

(NO. _____) (St. _____) (Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME A. J. Powers

PERSONAL AND STATISTICAL PARTICULARS

1 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
6 DATE OF BIRTH <u>Aug 29 1856</u> (Month) (Day) (Year)		
7 AGE <u>64 yrs. 4 mos. 13 ds.</u>		If LESS than 1 day, ... hrs. or ... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry business or establishment in which employed (or employer) _____		
9 BIRTHPLACE (City or town, or foreign country) <u>Arbela Mo</u>		
PARENTS	10 NAME OF FATHER <u>Joseph Powers</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	
	12 MAIDEN NAME OF MOTHER <u>Lois Wallace</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan 12 1921
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 12 1921 to Jan 12 1921, that I last saw him alive on Jan 12 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:
Suicide by Gun shot of 169 1070
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. D. Kildmore - coroner
Jan 12 1921 (Address) Memphis Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. J. Powers
(Address) Arbela Mo

15 Filed 7-1-1921 Registrar W. A. Jones

19 PLACE OF BURIAL OR REMOVAL Highway Iron Cemetery DATE OF BURIAL Jan 14 1921
20 UNDERTAKER W. A. Baskett ADDRESS Corinn Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH. *808*
 County Scotland Registration District No. _____ File No. _____
 Township Thompson Primary Registration District No. 203-3 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME A. J. Powers
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. (IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 - 1856
 AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 4 13

OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Garmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arbela Mo

10. NAME OF FATHER Joseph Powers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Arbela Mo

12. MAIDEN NAME OF MOTHER Wallace

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Arbela Mo

INFORMANT Mrs. A. J. Powers
 Address Arbela Mo
 FILED 9/8 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1921
 17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921 to Jan 12 1921, and that I last saw him alive on Jan 12 1921, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suicide by gun shot

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS. Skidmore Corona
 (Signed) J. D. Skidmore, M. D.
Jan 12, 1921 (Address) Memphis Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Victory Grove Cemetery DATE OF BURIAL Jan 14 1921
 UNDERTAKER South West ADDRESS Loria Mo.

BY LAW THEY ARE COMPLETE AS PRES

SUPPLEMENTARY

2958-1