

DECD JUL 17 1938

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

22251
Do Not Use This Space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 5629
 (b) Township Dyers Primary Registration District No. 34
 (c) City Higginsville (d) Street No. 400
 (e) Length of residence in city or town where death occurred 400 yrs. mos. ds. (f) How long in U. S., if of foreign birth? - yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Mr. Elizabeth Powell St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23, 1860

7. AGE YEARS 77 MONTHS 9 DAYS 7 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Higginsville, Mo

FATHER 13. NAME John W. Emson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Higginsville, Mo

MOTHER 15. MAIDEN NAME Annis E. Grant

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Mrs. Callie Burns, Odessa, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville DATE June 26, 1938

19. FUNERAL DIRECTOR (ADDRESS) Prefer Memorial, Higginsville, Mo.

20. FILED June 28, 1938 Agency Work Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23, 1938

22. I HEREBY CERTIFY That I attended deceased from May 31, 1938 to June 25, 1938
 I last saw her alive on June 23, 1938 Death is said to have occurred on the day stated above, at 7 P. M.
 The principal cause of death and related causes of importance were as follows:

Tremie Coma
Chronic Hypertensive Cardiorrenal Disease

Date of onset 6-10-38
years

Other contributory causes of importance: none

Name of operation none Date of no
 What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so specify _____
 (Signed) Ernest A. Mark, M. D.
Higginsville, Mo. (Address)

9592

STATEMENT BY LICENSED EMBALMER

I, W. Memershagen, Licensed Embalmer No. 1095
 hereby certify that the body recorded on the reverse side of this certificate was embalmed by Ray Weigert
 L. E.
 No. 2883 or by _____, Registered Apprentice No. _____
 working under my personal supervision.

Signed Walter Memershagen
 Licensed Embalmer No. 1095

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

22207
Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. _____
 (b) Township Chap Primary Registration District No. 562AA
 (c) City _____ (d) Street No. _____ Registered No. 34
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Elizabeth Powell

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 9 0

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER MOTHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Myocardial Infarction
Chronic Nephritis
Hypertensive Cardiovascular Disease
Renal Disease

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) E. M. Moore, M. D.

(Address) St. Ignace

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RECEIVE A FEE FOR CERTIFYING

REGIS

SUPPLEMENT

