

FN 11 MAY 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16351

Registration District No. 865

Primary Registration District No. 6143

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Cass Jwp
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 39 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Rural
(d) Street No. West of Simmons
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 71 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1940 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from
MAR 27 1940 to MAR 31 1940
that I last saw him alive on MAR 23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to Senility
Other conditions None
(Include pregnancy within 3 months of death)
Major findings: None
Of operations _____
Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME John Joseph Powers

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Susie Powers 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased March 22 1956
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days 9 If less than one day hr. _____ min. _____

9. Birthplace England
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Charles Powers

13. Birthplace Eng
(City, town, or county) (State or foreign country)

14. Maiden name Arva Boland

15. Birthplace Un
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Katherine Farris
(b) Address Houston Mo

17. (a) Burial (b) Date thereof April 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool, Mo

18. (a) Signature of funeral director Gaylord V. Elliott
(b) Address Cabool, Mo
19. (a) April 4 - 1940 (b) Mrs Lou McMillin
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature M. Dillman (M. D. or other) MD
Address Houston Date signed 4-1-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

District Health Officer No. 5

District File Number 540.576

Date Filed 51040

Signed Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, 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 this body is not embalmed, above space should be left blank. 51040