

JUN 6 1940
Registration District No. 516

Primary Registration District No. 5682

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linneburg

(b) City or town Wheeling
(If outside city or town limits, write "RURAL" and name of township)

(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 9
(Specify whether _____)

In this community 59 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linneburg

(c) City or town Wheeling
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Alvin Powers 620

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1940 hour 100 minute 20 A. M.

21. I hereby certify that I attended the deceased from MAY 29
_____, 19____, to _____, 19____;

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Emma Beckwith

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Aug. 6 1867
(Month) (Day) (Year)

that I last saw him alive on May 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration _____

8. AGE: Years Months Days If less than one day

72 9 23 ✓ hr. - min.

Due to Arteriosclerosis
Chronic Endocarditis

Other conditions (include pregnancy within 3 months of death) _____

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

10. Usual occupation Farmer (Retired)

11. Industry or business _____

MOTHER FATHER

12. Name Alvin Powers

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

14. Maiden name Edna J. Newberry

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Emma Higgins

(b) Address Wheeling Mo.

17. (a) Denial (b) Date thereof May 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeling Mo.

18. (a) Signature of funeral director James D. Jordan

(b) Address Chillicothe Mo.

19. (a) 5/31/40 (b) Mrs. J. P. Boone
(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? 460
(Specify type of place) (e) Means of injury _____

23. Signature D. F. Youll (M.D. or other) 570

Address Wheeling, Mo. Date signed 5/31/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 41;

District File Number 640-827

Date Filed JUN 5 1940

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.

Signed James D Gordon

Licensed Embalmer No. 1870

P. O. Address Lehillicoche ?

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.