

Registration District No. **1099**

Primary Registration District No. **5868**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Remondet
(b) City or town Beach Orchard Mo
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Glend Fay Powell

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased 0000 28 39
(Month) (Day) (Year)

8. AGE: Years _____ Months 15 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Luther Powell

18. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Whit Stewart

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

16. (a) Informant's own signature Luther Powell

(b) Address Beach Orchard Mo

17. (a) Reburial (b) Date thereof 4 11 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Methodist ch

18. (a) Signature of funeral director Pauline F. Howard

(b) Address Campbell 440

19. (a) April 11 40 (b) J. S. Greasy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Remondet

(c) City or town Beach Orchard Rural
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th
year 1940 hour 5 AM minutes _____ M.

21. I hereby certify that I attended the deceased from April 8th, 1940 to April 10, 1940
that I last saw her alive on April 9th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 5 da

Due to Pertussis 4 wk

Due to Double suppurative Otitis Media 8 da

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

Major findings: _____
Of operations _____

Of autopsy _____

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 John Danilow (M. D. or other) _____
Address Mulden Mo Date signed 4/14/40

PHYSICIAN
Underline the cause to which death should be charged statistically

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

REV. 6-17-30 I 11951

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.....

Licensed Embalmer No.....

P. O. Address.....

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.