

Registration District No. 533Primary Registration District No. 3027Registrar's No. 50

1. PLACE OF DEATH:

- (a) County Macon 2
- (b) City or town Macon
- (c) Name of hospital or institution:
110 Praire Ave.
(If outside city or town limits, write "RURAL" and name of township)
- (d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days3. (a) PRINT FULL NAME Sarah E. Powell 4003. (b) If veteran, name war none 3. (c) Social Security No. none4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widow6. (b) Name of husband or wife Unknown. 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased May 22, 1863
(Month) (Day) (Year)8. AGE: Years 77 Months 2 Days 89 If less than one day _____ hr. _____ min.9. Birthplace Macon County Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Housewife. 611. Industry or business 612. Name Pettis Summers13. Birthplace Missouri.
(City, town, or county) (State or foreign country)14. Maiden name Celia Green.15. Birthplace Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Jane Powell.(b) Address Macon, Mo.17. (a) Burial (b) Date thereof 7/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oakwood Cemetery.18. (a) Signature of funeral director Albert Skinner.(b) Address Macon, Missouri.19. (a) 8/5/40 (b) Seola Henderson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Macon
- (c) City or town Macon
(If outside city or town limits, write "RURAL")
- (d) Street No. 110 Prairae
(If rural, give location)
- (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 2:30 A. M. minute _____ M.21. I hereby certify that I attended the deceased from Macon
6, 1940 to July 30, 1940
that I last saw h. alive on July 28, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Cardio-vascular disease 5 yrs
disease 1.4 yrDue to wid marked cerebral arterio sclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) 1514

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? 476

While at work? JP. Gray (Specify type of place) (a) Means of injury _____23. Signature JP. Gray (M. D. or other) 1
Address Macon MO Date signed 8/5/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No. 10

District File Number 8-40-1548

Date Filed AUG 8 1940

H. I. Gronoway.

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.