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13-40
7-39
X23159

Registration District No. **411**

FILED DEC 10 1940
Secondary Registration District No. **2002**

Registrar's No. _____

1. PLACE OF DEATH: **JASPER.**
 (a) County **JASPER.**
 (b) City or town **JOPLIN**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **FREEMAN HOSPITAL.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 hrs.**
 (Specify whether years, months or days) **34 yrs.**

3. (a) PRINT FULL NAMES **BEULAH SHARP POWERS.**

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

4. Sex **FEMALE.** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOW.**

6. (b) Name of husband or wife **DR. H. C. POWERS.** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **SEPT 30 - 1880 =**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	1	3	hr. _____ min.

9. Birthplace **MOBERLEY MO -**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED -**

11. Industry or business _____

12. Name **DR. E. C. SHARP.**

13. Birthplace **CAIRO ILL.**
(City, town, or county) (State or foreign country)

14. Maiden name **ELLY V. DAVIS =**

15. Birthplace **BLACKBURN MO -**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward S. Powers**
(b) Address **Los Angeles California**

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

(c) Place: burial or cremation **MT HOPE CEM.**
(d) Signature of funeral director **Hubert Lind Co**
(e) Address **Joplin Missouri**
(f) Date received from registrar **11-4-40** (g) Registrar's signature **Ed Danner**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **JASPER**
 (c) City or town **JOPLIN**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **RESIDENCE - CONNOR HOTEL.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **1**
year **1940** hour **4** minute **55 P.** M.

21. I hereby certify that I attended the deceased from **August**
19**39** to **NOV 01**, 19**40**
that I last saw **her** alive on **NOV 01**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack** Duration _____
Chronic Myocarditis 8 years

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(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?
3720 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **Hubert Lind** (M. D. or other) _____
Address **Joplin Mo** Date signed _____

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

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. *959*

P. O. Address *Spencer Mass*

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, fact should be so stated above.