

Registration District No. 654 Primary Registration District No. 5872 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Missouri Co.  
(b) City or town Near Coates MO  
(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 \_\_\_\_\_ (Specify whether)  
In this community 5 years years, months or days

3. (a) PRINT FULL NAME Charles Henry Powers  
3. (b) If veteran, name war none  
3. (c) Social Security No. 740

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Yes  
6. (b) Name of husband or wife Maude Powell 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased August 6 1876  
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 10 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Andrew Jackson Powers  
13. Birthplace Bullard Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Ellen Oliver  
15. Birthplace Coates Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Maude Powell  
(b) Address Coates Mo

17. (a) Rural (b) Date thereof 11 17-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. 300

18. (a) Signature of funeral director Wm. W. Co  
(b) Address St. Louis Mo

19. (a) 12-10-1940 (b) Tom Bragance  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Missouri  
(c) City or town Near Coates MO  
(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 Nov. day 17-1940  
year 19 hour 30 minute A. M.

21. I hereby certify that I attended the deceased from Nov 10-1940  
to Nov 17-1940  
that I last saw him alive on Nov 16-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis & Acute Intestinal Hemorrhage  
Duration \_\_\_\_\_

Due to Can't say

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none  
Of autopsy none  
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) \_\_\_\_\_  
(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 500 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. C. McLean (M. D. or other) \_\_\_\_\_  
Address Bullard Mo Date signed 11-17-1940

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

62-40-2

1208

**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 William C. Shelton

Licensed Embalmer No. 3929

P. O. Address Steele, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 39435-

Registration District No. 656

Primary Registration District No. 5873

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Pemscot  
(b) City or town Colesburg  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Chas Henry 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. m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive. \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 3 10 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 11 day 17  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis and Gastro Intestinal ulceration

Due to Can't say about nephritis - N. M. J.

Other conditions. (Include pregnancy within 3 months of death) 132

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-39435 1940