

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22107**

FILED JUN 30 1943
Registration District No. **270**

Primary Registration District No. **43-99-5910**

Registrar's No. **40**

1. PLACE OF DEATH:

(a) County Pemiscot

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

(c) Name of hospital or institution:
None 1 Pemiscot Jungs
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether)

In this community 10 Months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Tennessee (b) County Shelby **999**

(c) City or town Memphis
(If outside city or town limits, write "RURAL") **40**

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country Citizen of U.S.A. **2**

3. (a) PRINTED FULL NAME Matthews Harry Powers

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1943 hour 11 minute 30 A.M.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Ollie Powers

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased November 28, 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from MAY 1, 1943, to JUNE 12, 1943;
that I last saw him alive on JUNE 12, 1943;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>6</u>	<u>14</u>	br. min.

Immediate cause of death PARALYTIC STROKE **10 DAYS**

Due to _____

Due to _____

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

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

10. Usual occupation Retired Civil Engineer

11. Industry or business as above

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Georgia McCornic

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

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 0

16. (a) Informant Mrs Ollie Powers

(b) Address Cottonwood Point, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof June 13, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville, Mo.

23. Signature J. L. La Forge (M. D. or other) **M.D.**
Address CARUTHERSVILLE, MO. Date signed 6-15-43

18. (a) Signature of funeral director J. L. La Forge

(b) Address Caruthersville, Mo.

19. (a) 6-13-1943 (Date received local registrar)

(b) Jessie N. Markey (Registrar's signature)

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

6-43-209

JUL 20 1943

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

J. La Forge

Licensed Embalmer No. *3082*

P. O. Address *Canthersville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
40
Registrar's No. _____

Registration District No. 270

Primary Registration District No. 4399

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

1. PLACE OF DEATH: Permisist

(a) County.....

(b) City or town.....
(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.....
years, months or days)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Matthews Harry Power

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1943 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 Psychic Shock, 10 day
Cerebral Hemorrhage

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 Nov 28 1913
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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).....

(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) _____ (c) Means of injury.....

23. Signature P. J. Quinn (M. D. or other).....
Address _____ Date signed _____

S-22107