

S. No. 2
1-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34174

State File No. _____

FILED OCT 18 1945

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

3. (a) PRINT FULL NAME: Lulu 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 Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: March 23 - 1881
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace: College Mound Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: Music Instructor

11. Industry or business _____

12. Name: William McRae

13. Birthplace: No Record 9
(City, town, or county) (State or foreign country)

14. Maiden name: Martha Dameron

15. Birthplace: No Record 11
(City, town, or county) (State or foreign country)

16. (a) Informant: R E Sharp

(b) Address: Macon Mo

17. (a) Burial (b) Date thereof: Sept 5 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oakwood Cem

18. (a) Signature of funeral director: Robert Skemer

(b) Address: Macon Mo

19. (a) 10/1/45 (b) Jara B Stunkle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61
(c) City or town Macon 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1945 hour 1 minute P M.

21. I hereby certify that I attended the deceased from Sept 30 to Sept 1, 1945
that I last saw her alive on Dec 31, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis Duration: Sudden

Due to _____
Due to _____

Other conditions: Hypertension - Arteriosclerosis
(Include pregnancy within 6 months of death)

Major findings: Of operations: _____
Of autopsy: 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) (e) Means of injury: _____

23. Signature: Edward Welch (M. D. or other) _____
Address: Macon Mo Date signed: 9/6/45

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

MOTHER FATHER

1037

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 10-45-1576

Date Filed OCT 17 1945

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

Albert Skinner

Licensed Embalmer No.

75-1

P. O. Address

Macon 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.