

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Boyer  
State File No. 28567

FILED SEP 10 1947

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 279

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

1. PLACE OF DEATH:

(a) County Pettis

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

(c) Name of hospital or institution:  
Bashwell Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 weeks  
(Specify whether)

In this community Life  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis 80

(c) City or town Hughesville 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 1

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Katherine L. Powell

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1947 hour 12 minute 50P M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Dee R. 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased: 12 15 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 22, 1947, to Aug 12, 1947.

that I last saw or alive on Aug 12, 1947, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

72 7 27 hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma Lung

Due to Carcinoma of uterus

9. Birthplace Pettis Co Mo  
(City, town, or country) (State or foreign country)

10. Usual occupation at home

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

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

12. Name Jonathan D Claybough

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

14. Maiden name Agusta Washburn

15. Birthplace KY  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant Dee R Powell

(b) Address Hughesville Mo

17. (a) Burial (b) Date thereof 8-14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mum. Park

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

(b) Address Scalalia Mo

19. (a) 8/14/47 (b) Petty Yeager  
(Date received local Registrar) (Registrar Signature)

201 (Licensed Embalmer's Statement on Reverse Side)

23. Signature W. Boyer (M. D. or other) MD

Address Scalalia Mo Date signed 8-13-47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-9-47

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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 Geo Dillard

Licensed Embalmer No. 3868

P. O. Address Sidell

**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.