

FILED MAY 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12576

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 4281 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY Lewis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lewis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Canton Canton		c. LENGTH OF STAY (in this place) 50 yrs.	c. CITY OR TOWN Canton
d. FULL NAME OF HOSPITAL OR INSTITUTION At home		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Fermen b. (Middle) - c. (Last) Powell			4. DATE OF DEATH (Month) (Day) (Year) May 7, 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 12, 1881
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman	11. BIRTHPLACE (City and State or Foreign Country) Adams County, Ill.
10b. KIND OF BUSINESS OR INDUSTRY Commercial		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Powell		13b. MOTHER'S MAIDEN NAME Ora Lynn	14. NAME OF HUSBAND OR WIFE Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dug Powell, Canton, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Valvular disease of heart INTERVAL BETWEEN ONSET AND DEATH 2 wks ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4214	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
22. I hereby certify that I attended the deceased from April 16, 1954, to May 8, 1954, that I last saw the deceased alive on May 7, 1954, and that death occurred at 10 P. M., from the causes and on the date stated above.			
23a. SIGNATURE P. W. Jennings, M.D.		23b. ADDRESS CANTON Mo.	
23c. DATE SIGNED 5/8/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 8, 1954	24c. NAME OF CEMETERY OR CREMATORY Forest Grove	24d. LOCATION (City, town, or county) (State) Canton, Lewis Co. Mo.
DATE REC'D BY LOCAL REG. 5-8-54	REGISTRAR'S SIGNATURE P.W. Jennings, M.D.	2. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl H. Buckley, Canton, Mo.	

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

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E. L.

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Carl H. Barkley*.....

Licensed Embalmer No. *76*.....

P. O. Address *Centon*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.