

FILED FEB 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4143

State File No.

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville		c. LENGTH OF STAY (in this place) 44 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION In front of 525 Vine St.		STREET ADDRESS (If rural, give location) 612 Sixth St.	

3. NAME OF DECEASED (Type or Print) a. (First) Neellie	b. (Middle) Givens	c. (Last) Powell	4. DATE OF DEATH (Month) (Day) (Year) February 15 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 24-1873	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign Country) Cooper County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Clair Givens.	13b. MOTHER'S MAIDEN NAME Mary Ogden.	14. NAME OF HUSBAND OR WIFE Chas. W. Powell.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Earl Powell, Boonville, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chr. Interstitial nephritis 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 13, 1957, to Feb 15, 1957, that I last saw the deceased alive on Jan 10, 1957, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M L Deekraqui M.D.	23b. ADDRESS Boonville, Mo	23c. DATE SIGNED 2/16/57
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24a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify) Burial	24b. DATE Feb. 17 1957	24c. NAME OF CEMETERY OR CREMATORY Walnut Grove	24d. LOCATION (City, town, or county) (State) Boonville, Missouri.
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DATE REC'D BY LOCAL REG. 2/16/57	REGISTRAR'S SIGNATURE Stooper	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodman & Boiler, Boonville, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

3210

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..... William W. Wood

Licensed Embalmer No. 4539 P. O. Address Boonville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.