WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Mark Co

Township ____ or Village Pamuel Mo or City ____ (No. ____ St.: ____ Ward)

Registration District No. 1057 File No. 43736-1

Primary Registration District No. 6214 Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Dortha Lavon Powers

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | COLOR OR RACE: White | SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb 15 (Month) (Day), 1916 (Year)

AGE: ____ yrs. 9 mos. 29 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓

BIRTHPLACE (City or town, State or foreign country): Mark Co. Mo

PARENTS

NAME OF FATHER: J. M. Powers

BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri

MAIDEN NAME OF MOTHER: ~~Rosa Murphy~~ H. J. Powers

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Grundy Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Powers

(ADDRESS) Pamuel Mo

Filed Dec. 15 1917 T M Cox REGISTRAR

misplaced

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec. 14 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 24, 1917, to Dec 14, 1917, that I last saw her alive on Dec 13, 1917, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

11A Bronchial Pneumonia
10MA
11SA

(Duration) ____ yrs. ____ mos. 4 ds.

Contributory (Secondary) Tonsilitis & La Grip

(Duration) ____ yrs. ____ mos. 16 ds.

(Signed) Egbert Grayson M. D.

8 Dec 14 1917 (Address) Parnell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Oakland Mark Co Mo | DATE OF BURIAL: Dec 15 1917

UNDERTAKER: Ang Eaton | ADDRESS: Pamell Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

If death occurred ... hospital or institu... give its NAME in... of street and numb...

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

DATE OF BIRTH

_____ (Month) _____ (Day) _____ (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 19__
(Month) (Day) (Y...

I HEREBY CERTIFY, that I attended deceased ...

_____, 191__, to _____, 19...

that I last saw h... alive on _____, 19...

and that death occurred, on the date stated above, at ...

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes: (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	**ADDRESS**

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); ... *meninges, peritoneum*, etc.,