LOCAL REGISTRAR'S RECORD — DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County North

Township Green

or Village

or City Purcell P.O. Mo

Registration District No. 1057

Primary Registration District No. 6214

File No. 44119

Registered No. 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Burnace Elane Powers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Female	White	Single

6 DATE OF BIRTH: May 24 (Month) (Day) 1915 (Year)

7 AGE: 3 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Butler Jo. North Co Mo

PARENTS

10 NAME OF FATHER: Ben Jasmin Powers

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.

12 MAIDEN NAME OF MOTHER: Rugby Gerald

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Carroll
(Address) Purcell Mo

15 Filed Nov 6, 1918 E. T. M. Cox Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 2 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 27, 1918, to Nov. 2nd, 1918, that I last saw h.er alive on November 2 1918, and that death occurred, on the date stated above, at about 10 p.m.

The CAUSE OF DEATH* was as follows:

Influenza IIA

IID

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) O. P. M. Mills M. D.

Nov. 5, 1918 (Address) Grant City, Mo.

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Oakford Cemetery — DATE OF BURIAL: Nov. 3, 1918

20 UNDERTAKER: Roof Sutan — ADDRESS: Purcell Mo

LOCAL REGISTRAR—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.

WHERE PLANKLE, WITH UNFADING INK. THIS IS A PERMANENT