LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

22588

PLACE OF DEATH

County Boone — Registration District No. 75 — File No.

Township Perche — Primary Registration District No. 5114 — Registered No.

City (No. , St. Ward)

FULL NAME Not named

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

th of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
ale	White	infant

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

ATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 8, 1924

GE	YEARS	MONTHS	DAYS	If LESS than 1 day, 4 hrs. or min.

CCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

RTHPLACE (CITY OR TOWN) Harrisburg
(STATE OR COUNTRY) Mo

0. NAME OF FATHER W R. Powell

1. BIRTHPLACE OF FATHER (CITY OR TOWN) Boon Co
(STATE OR COUNTRY)

2. MAIDEN NAME OF MOTHER Lorena Mead

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) Boon Co
(STATE OR COUNTRY)

INFORMANT Mrs Lorena Powell
(Address) Harrisburg Mo

FILED Aug 10, 1924 J. T. Wood
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8 1924

17.
I HEREBY CERTIFY, That I attended deceased from Aug 8, 1924, to Aug 8, 1924 that I last saw him alive on Aug 8, 1924, and that death occurred, on the date stated above, at 9P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Deformity of Larynx
Heart
159C
157D
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 159B
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H Gullett, M. D
, 19 (Address) Harrisburg Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Harrisburg mo. — DATE OF BURIAL Aug 9th 1924

20. UNDERTAKER Wm Whitmarsh a neighbor coffin come from R. L Beasley & Muller mo — ADDRESS Harrisburg

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. ..... W

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on....., 19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

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(Signed).....

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURI

20. UNDERTAKER | ADDRESS