

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

Do not use this space.

1. PLACE OF DEATH

County Macon
Township.....
City Macon (No.....)

Registration District No. 533
Primary Registration District No. 3027

File No. 303-46^a
Registered No. 91
St. _____ Ward _____

2. FULL NAME

Henry Lee Powell
(e) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Stuttgart Ark.
(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 25 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 6 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Macon Co.
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Henry M Powell

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

12. MAIDEN NAME OF MOTHER Stella Mathews

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

14. INFORMANT Lou Ella Powell
(Address) Stuttgart Ark.

15. FILED 11-5-25 Dora Holman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1925

17. I HEREBY CERTIFY That I attended deceased from 10/25 to 10/25 1925
that I last saw alive on Oct 25, 1925, and that death occurred, on the date stated above, at 12 D. 2m

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infection from his own hand

CONTRIBUTORY (SECONDARY) Prisaults
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) D. M. Reeves, M. D.

*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 Orkwood DATE OF BURIAL Nov 1 1925
20. UNDERTAKER Lee R Vandener ADDRESS Macon Mo

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN

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

1. PLACE OF DEATH.

County Macon Registration District No. 533 File No. _____
 Township _____ Primary Registration District No. 3027 Registered No. 91
 City Macon (No. _____) St. _____ Ward _____

2. FULL NAME Henry Lee Powell
 (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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>		
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)				
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)				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 - 19 20 -
 17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Infection from his own stroke over and over
not infected
not infected by stroke
 CONTRIBUTORY (SECONDARY) not. Hypertension
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? for prostate
 WHAT TEST CONFIRMED DIAGNOSIS blood, white
 (Signed) Dr. J. M. D. (Address) Broken Down

PARENTS

SUPPLEMENTARY

14. INFORMANT (Address) _____
 15. FILED 4-6-26 Dora Helms REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
A. M. Lewis 19____
 20. UNDERTAKER (Address) Physician in. Care

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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