

MAY 28 1927

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

Do not use this space.  
Slokes 2316

1. PLACE OF DEATH

County Macon Registration District No. 535  
Township Macon Primary Registration District No. 5720  
City Jackspruille P.R.#3

File No. 8  
Registered No. 88  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

V. Allie Powell

(a) Residence No. Jackspruille, Mo. P.R.#3 Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 1 1/2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 24 - 1910

7. AGE YEARS 16 MONTHS 3 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Glenn Powell

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

12. MAIDEN NAME OF MOTHER Reta Perkins

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

14. INFORMANT Mrs Glenn Powell  
(Address) R R Jackspruille Mo

15. May 10, 1927 J. J. King  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 22 1927  
17.

I HEREBY CERTIFY, That I attended deceased from April 21st, 1927, to April 22nd, 1927 that I last saw her alive on April 19th, 1927, and that death occurred, on the date stated above, at 12:15 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Parenchymatous Nephritis

Acute Uræmia (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spectroscopic & Arterial analysis  
(Signed) J. B. Stokes, M. D.

4123, 1927 (Address) Macon, 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 Fairview DATE OF BURIAL Apr 24 1927

20. UNDERTAKER Albert Skinner ADDRESS Macon

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.

# 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, Composer, 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, 6 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 neoplasm); *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.; *Broncho-pneumonia* (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: "Certificates 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 BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County Macon Registration District No. 535  
 Township Marion Primary Registration District No. 3720  
 City (No. ....) .....

File No. 188  
 Registered No. 88  
 St. .... Ward)

**2. FULL NAME**

Ellie Powell  
 (a) Residence. No. .... City, Co., and State. ....  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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.
	16	3	18	

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

9. BIRTHPLACE (CITY OR TOWN) Marion, Mo.  
 (STATE OR COUNTRY) .....

10. NAME OF FATHER Elmer Powell

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

12. MAIDEN NAME OF MOTHER Reba Perkins

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

14. INFORMANT Mrs. Elmer Powell  
 (Address) Marion, Mo.

15. Myrtle G. King  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1927  
 17. ....

I HEREBY CERTIFY, That I attended deceased from 21st 1927 to 27th 1927  
 that I last saw him alive on 20th 1927 and that death occurred, on the date stated above, at 7:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute parenchymatous nephritis following measles  
acute meningitis

CONTRIBUTORY (SECONDARY) acute meningitis  
 (duration) yrs. mos. ds. ....

18. WHERE WAS DISEASE CONTRACTED .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

19. WAS THERE AN AUTOPSY? .....

WHICH TEST CONFIRMED DIAGNOSIS? Smear  
 (Signed) J. B. Stuber M. D.  
 (Address) Marion, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Marion DATE OF BURIAL July 27

20. UNDERTAKER Albert Skinner ADDRESS Marion, Mo.

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.

DEPARTMENT RECORD

SUPERINTENDENT

S-12316