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

Do not use this space.

MAR 16 1928

3939

1. PLACE OF DEATH

County: Ark Ozarks — Registration District No.: 26 — File No.:

Township: Jackson — Primary Registration District No.: 5034 — Registered No.: 20

City: Mexico Mo (No. ..... St. ..... Ward)

2. FULL NAME Lucindia Alice 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: R. W. Powell

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 23 1857

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	—	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(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): Indiana

PARENTS

10. NAME OF FATHER: Simon Buxton

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

12. MAIDEN NAME OF MOTHER: Marie Hawkins

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

14. INFORMANT: R W Powell
(Address): Mexico

15. FILED: Feby 3rd 19 28 Fred Milligan, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 1st 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1928, to Jan 30, 1928 that I last saw h. alive on Jan. 30, 1928, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82 Apoplexy
97 Well
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Arteriosclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF: No
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. C. Jones, M. D.
, 19 (Address)

*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	DATE OF BURIAL
Swarts McCann	2-3 1928
20. UNDERTAKER	**ADDRESS**
H U Brecht & Son	Mexico 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.