

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

Do not use this space.

29980

**1. PLACE OF DEATH**

County Chariton  
Towship \_\_\_\_\_  
City Salisbury Mo

Registration District No. 170  
Primary Registration District No. 4104

File No. \_\_\_\_\_  
Registered No. 58  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Grover Cleveland Powell

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-22-1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
43 | 4 | 25

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Labour  
(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) Mo

**10. NAME OF FATHER**

Geo Powell

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo

**12. MAIDEN NAME OF MOTHER**

Mary Estromper

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo

**14.**

INFORMANT Mrs. Effie Powell  
(Address) Salisbury Mo

**15.**

FILED 10/6 1928 W. H. ... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-17 1928

17. I HEREBY CERTIFY That I attended deceased from about August 1 1928 to Sept 17 1928 that I last saw h. alive on Sept 17 1928, and that death occurred, on the date stated above, at 7:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Respiratory Tuberculosis  
23A

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH: no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS: X-Ray

(Signed) William W. Bellows, M. D.

, 19 (Address) Salisbury, 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** DATE OF BURIAL

Salisbury Ill 9-19 1928

**20. UNDERTAKER**

Winkelmeier Bros Salisbury

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.

24 1928

