

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

Do not use this space.

31103

1. PLACE OF DEATH

County Gasper
Township Madison
City Castroville (No. McCune Branch Hospital Ward)

Registration District No. 408
Primary Registration District No. 3770

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence. No. Sarcoxie, Mo. St. Ward. _____

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 27, 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
16 8 16

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER James Powers

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

12. MAIDEN NAME OF MOTHER Lanning

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

14. INFORMANT James W. Powers
(Address) Sarcoxie, Mo.

15. FILED 9/13 1929 Castroville REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 12, 1929 that I last saw h. em. alive on Sept 12, 1929, and that death occurred, on the date stated above, at 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1210 appendectomy with
1211 general peritonitis
(duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY appendicitis
(SECONDARY) (duration) _____ yrs. _____ mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 10-29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. B. York, M. D.
, 19 (Address) Sarcoxie, Mo.

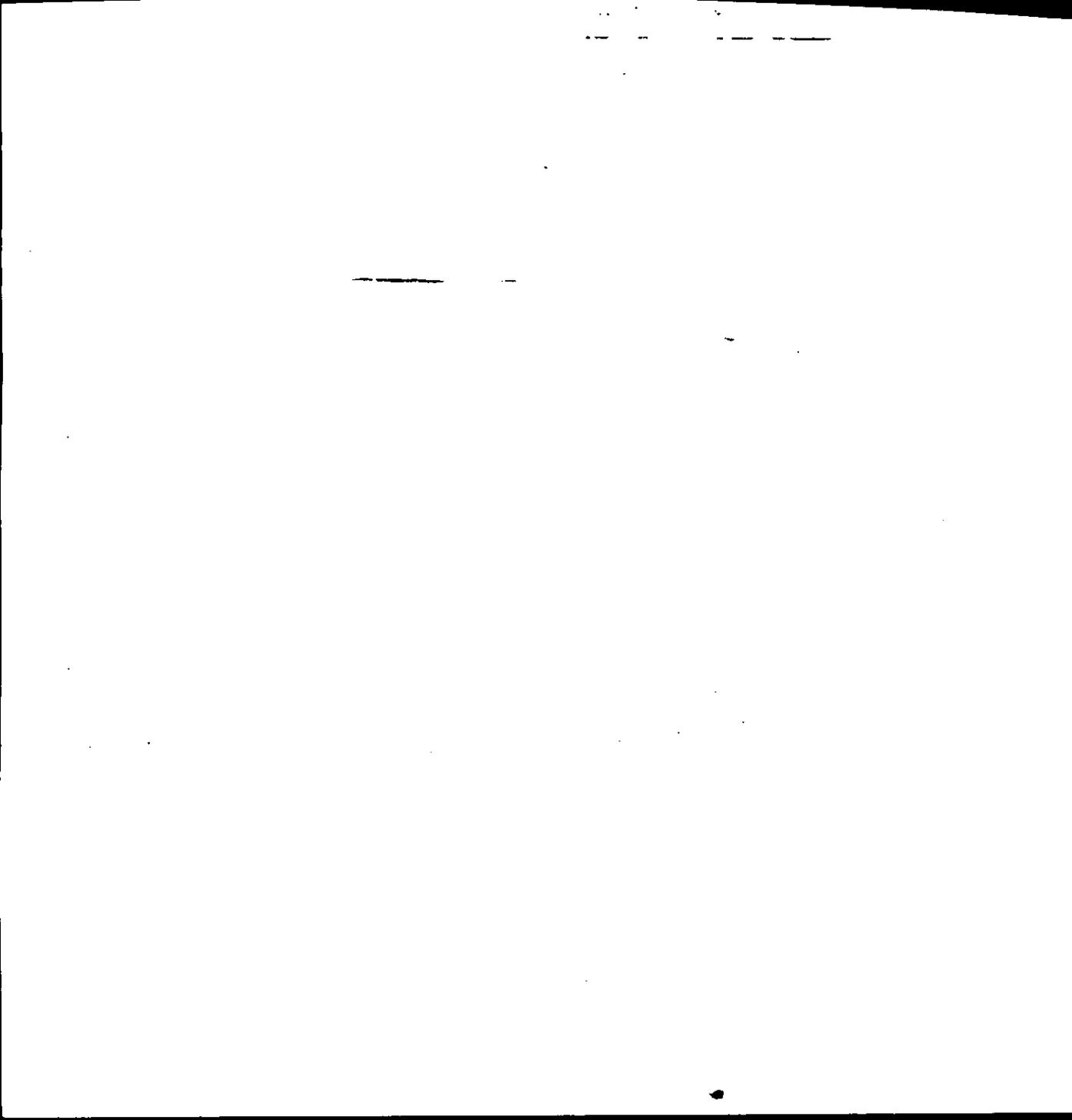
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

Sarcoxie Cemetery 19

20. UNDERTAKER ADDRESS

Sarcoxie and Co. Sarcoxie
M.C. Thayer



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Asper Registration District No. 408 File No. _____
 Township _____ Primary Registration District No. 2020 Registered No. _____
 City Northage (No. _____) St. _____ Ward _____

2. FULL NAME

Lyla Hazel Powers
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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)

14. INFORMANT _____ (Address)

15. FILED 9/12, 1929 C. W. Schaub REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ 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:

CONTRIBUTORY (SECONDARY) _____ (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) _____, 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

Sarcenic Cemetery

9/13 1929

20. UNDERTAKER

ADDRESS

FIGATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-31103