

SEP 26 1930

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

Do not use this space.

W. J. Coffey
27477 per

1. PLACE OF DEATH

County *Boonville* Registration District No. *651*
Township *Little Prairie* Primary Registration District No. *5862*
City *Boonville* No. _____ St. _____ Ward _____

File No. _____
Registered No. *119*
St. _____ Ward _____

2. FULL NAME

Jane Powers
(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 *Mrs. Gene Dorinda*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 17 1878*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 3 26

8. OCCUPATION OF DECEASED *Farmer*
(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) *Boonville Ark.*

10. NAME OF FATHER *Bill Powers*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Boonville Ark.*
12. MAIDEN NAME OF MOTHER *N.K.*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT *Frank Powers*
(Address) *Carey Parkville Mo.*

15. FILE NO. *140-30* *Ada Martin* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-13 1930*

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that death occurred, on the date stated above, at _____, 10 *A*. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Struck by an automobile (unavoidable accident) (Verdict of Coroner Jury)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Accident*
This accident happened in _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *210 M*
IF NOT AT PLACE OF DEATH

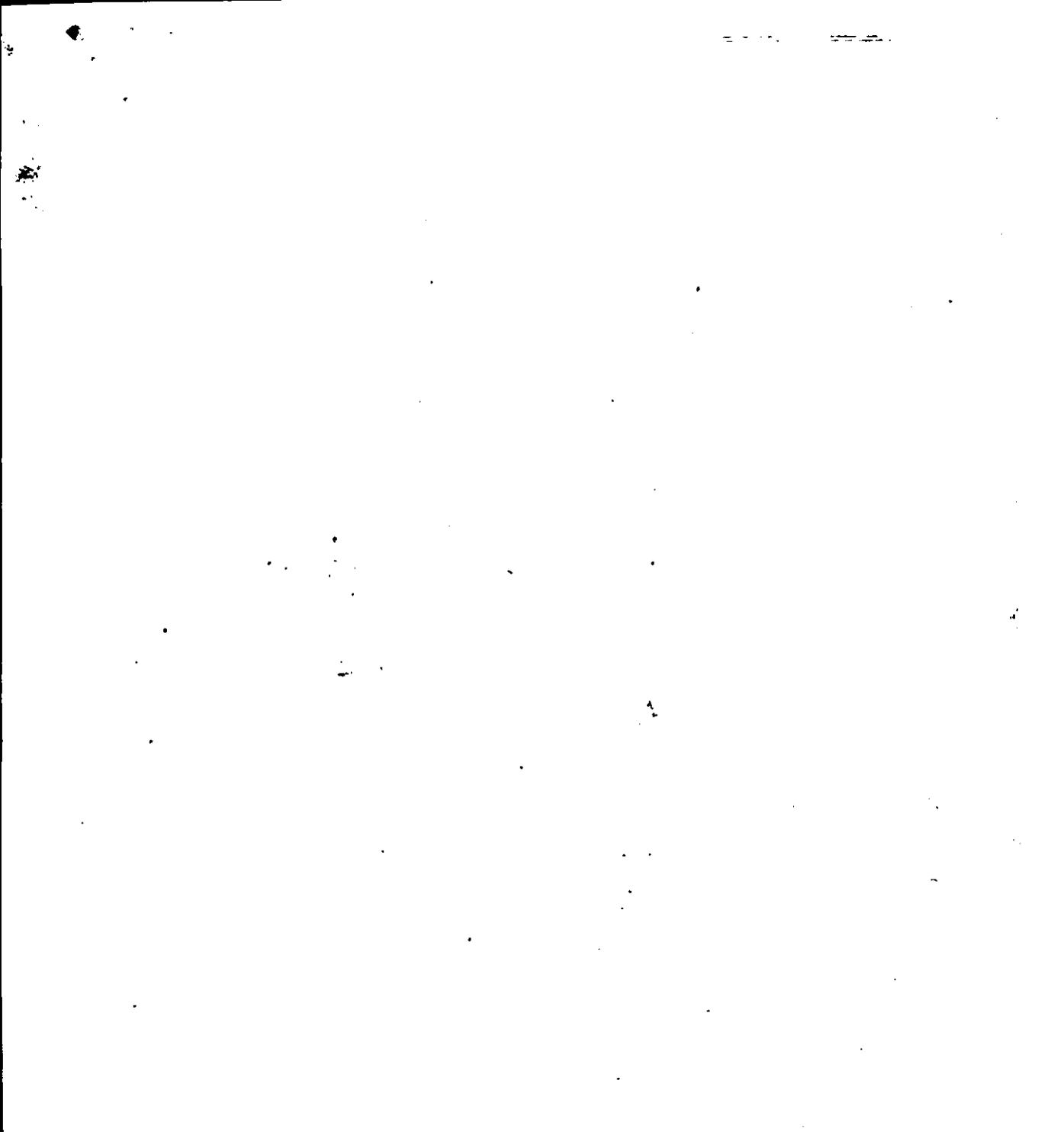
9 DID AN OPERATION PRECEDE DEATH? *no.* DATE OF *75 B*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *James P. Vickrey (Coroner)* M. D.
Aug 13 1930 (Address) *Braggards Mo.*

*State the DISEASE CAUSING DEATH, or if 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 *Mound cemetery* DATE OF BURIAL *8-14 1930*

20. UNDERTAKER *Friends* ADDRESS *Boonville Mo*



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lemmon Registration District No. 65-1 File No. _____
 Township Little Prairie Primary Registration District No. 5-862 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Jane 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (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 _____
 (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 Sept 30 1930 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/3 1930

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Struck by an auto
(unavoidable accident)
This man was walking
and was struck by car. Dr.
unknown, driver was
drunk. This accident happened
in Co. Perry of Little Prairie, near
Proggadoris.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

WAS THERE AN AUTOPSY? 1/30

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 _____

19

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SH. BY EE FOR CERTIFICATES UNTI. THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-27477