

APR 22 '935

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

Do not use this space.

9777

1. PLACE OF DEATH

County *McDonald*Registration District No. *518*Township *Anderson*Primary Registration District No. *4574*City *Anderson* (No. _____)

St. _____ Ward _____

File No. *1-1935*Registered No. *11*2. FULL NAME *James Edward 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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND-OF- (OR) WIFE OF

Isabel Powers

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

Nov 17-1859

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

*75**4**7*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

John H. Powers

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

Elizabeth Christell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT

(ADDRESS)

Mrs. Fred Marker Anderson mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

Calkeasoa, Ind. 3-25-1935

19. UNDERTAKER

(ADDRESS)

Chas. W. Williams Washington mo

20. FILED

*March 16 1935**Mrs. Lee Harber*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 24, 1935*I HEREBY CERTIFY, That I attended deceased from *Mar 17 1935* to *Mar 29 1935*I last saw him alive on *Mar 11 1935* Death is said to have occurred on the date stated above, at *4:30* p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Other contributory causes of importance:

Name of operation *none* Date of _____What test confirmed diagnosis *none* Was there an autopsy *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *J. B. Bunc* M. D.(Address) *Anderson, Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

