

REC'D MAR 20 1938

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

6577  
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 247  
(b) Township Washington Primary Registration District No. 2347 Registered No. 13  
(c) City Long Lane (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Fred Powell 400

(a) Residence, No. Long Lane mo. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie Powell  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-10-1884  
7. AGE YEARS 54 MONTHS \_\_\_\_\_ DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as 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) Dallas Co. (STATE OR COUNTRY) mo.

FATHER 13. NAME Marion Powell

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Carrie Powell (ADDRESS) Long Lane mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty DATE 3-7-38

19. FUNERAL DIRECTOR (NAME) J. B. Jones (ADDRESS) Buffalo

20. FILED 3-10-1938 J. J. Galbraith Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-28, 1938

22. I HEREBY CERTIFY, That I attended deceased from on 2-28, 1938, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him alive on 2-28, 1938. Death is said to have occurred on the date stated above, at 10 a m.  
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 2-28-38

Other contributory causes of importance:

Jonny saw him once and he was unconscious

Name of operation no op Date of \_\_\_\_\_  
What test confirmed diagnosis? usual 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) E. J. Hammer, M. D.

(Address) Buffalo - Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

*Clyde Montgomery*

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Clyde Montgomery*

Licensed Embalmer No. *3592*

P. O. Address *Buffalo Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.