

REC'D MAY 11 1938

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

Howards
15214
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 529
(b) Township Chariton Primary Registration District No. 5768 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(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 John F. Powell 400
(a) Residence, No. _____ County _____ St. (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 Minnie M. Powell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 15, 1865

7. AGE YEARS 73 MONTHS 1 DAYS 20 If LESS than 1 day, _____ hrs. _____ min.

OCCUPATION 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. Gen. farming
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Macon County, (STATE OR COUNTRY) Missouri

FATHER 13. NAME Wm. Powell,
14. BIRTHPLACE (CITY OR TOWN) (Unknown) (STATE OR COUNTRY) N. Carolina

MOTHER 15. MAIDEN NAME Nancy Banning,
16. BIRTHPLACE (CITY OR TOWN) (Unknown) (STATE OR COUNTRY) N. Carolina

17. INFORMANT Mrs. John F. Powell (ADDRESS) Macon, Mo.

18. BURIAL PLACE Union Cem. Macon Co. DATE April 7, 1938

19. FUNERAL DIRECTOR Edbert Skinner (ADDRESS) Macon, Mo.

20. FILED _____, 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5, 1938

22. I HEREBY CERTIFY That I attended deceased from Feb. 5, 1937 to April 5, 1938
I last saw him alive on March 28, 1938 Death is said to have occurred on the date stated above, at 11:20 P.M.

The principal cause of death and related causes of importance were as follows:
Cardiovascular disease of 5 yrs. duration Date of onset about 4 yrs
Bronchial asthma 10 yrs

Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical 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. J. Howards M. _____
Macon Mo.
28-72 (Address) _____

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.

STATEMENT BY LICENSED EMBALMER

I, Russell Barber, Licensed Embalmer No. 3848

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Russell Barber
Licensed Embalmer No. 3848

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

15.214

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 329
(b) Township Chariton Primary Registration District No. 3725 Registered No. _____
(c) City _____ (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

John F. Powell
(a) Residence, No. _____ County _____ 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Minnie M. Powell OR WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 15, 1865

7. AGE YEARS 73 MONTHS 1 DAYS 20 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. Gen Farming
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Macon County Missouri (STATE OR COUNTRY)

FATHER 13. NAME Wm Powell

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

MOTHER 15. MAIDEN NAME Nancy Banning

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

17. INFORMANT Mrs John F Powell (ADDRESS) Macon Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Macon Cem Macon Mo. DATE Apr 7 1938

19. FUNERAL DIRECTOR Albert Skinner (ADDRESS) Macon Mo.

20. FILED June 26 1938 Mrs R W Powell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5, 1938

22. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1938 to April 5, 1938
I last saw him alive on March 28, 1938. Death is said to have occurred on the date stated above, at 11:20 P.
The principal cause of death and related causes of importance were as follows:

Cardiovascular Disease
Bronchial Asthma
Other contributory causes of importance: _____
Date of onset _____

Name of operation _____ Date of _____
What test confirmed diagnosis clinical Was there an autopsy? _____

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? _____
If so, specify _____
(Signed) J P Gronoway, M. D.
(Address) Macon Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

