

1939 JUN 15

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

19124
Do not use this space.

1. PLACE OF DEATH

(a) County Livingston Registration District No. 508
(b) Township Chillicothe Primary Registration District No. 5674
(c) City Chi (d) Street No. _____ Registered No. 74
(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

400 Joseph Powell
(a) Residence, No. Chillicothe Mo. Route #3 (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 (write the word) SINGLE
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 10 - 1892
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 0 6
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. TRUCK DRIVER
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation 15.

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

FATHER 13. NAME William Cop POWELL

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

MOTHER 15. MAIDEN NAME REBECCA COOK

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

17. INFORMANT Le Roy M. Drwin (ADDRESS) Chillicothe Mo. Route #3

18. BURIAL, CREMATION, OR REMOVAL PLACE EDGEWOOD CEM DATE MAY 18 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. A. Meinershagen Chillicothe Mo.

20. FILED 5-18-39 H. M. Drwin M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 11th, 1939, to May 16, 1939.
I last saw him alive on May 16, 1939. Death is said to have occurred on the date stated above, at 3:14 A.M.
The principal cause of death and related causes of importance were as follows:

Acute Double Lobar Pneumonia Date of onset _____
Other contributory causes of importance: Pleurisy

Name of operation n.d. Date of n.d.
What test confirmed diagnosis? Clinical Was there an autopsy? n.d.

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? n.d.
If so, specify _____
(Signed) Dr. Amy Lamuck D.O.
(Address) Chillicothe Mo.

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.

RECEIVED
District Health Officer No
District File Number 11-39
Date Filed JUN 14 19

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,

Elmer Thomas

or by

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

Signed

Elmer Thomas

Licensed Embalmer No.

2640

P. O. Address

Chillicothe Mo

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.)

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