

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38651

State File No. _____

Registrar's No. _____

4415

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wheatley Provident
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CARROLL
(c) City or town CARROLLTON
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME ANNA LOU POWELL

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex FE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Feb. 22, 1928
(Month) (Day) (Year)

8. AGE: Years 11 Months 8 Days 28 If less than one day hr. min.

9. Birthplace Mangum, Okla. (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Cecil Powell

13. Birthplace Jackson Miss. (City, town, or county) (State or foreign country)

14. Maiden name Goldie McNeill

15. Birthplace Carrollton, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Goldie Powell

(b) Address Carrollton, Mo.

17. (a) Burial (b) Date thereof 11-19-39
(Place, occasion, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Carrollton, Mo.

18. (a) Signature of funeral director J. S. Beck

(b) Address 201 S. Main, Carrollton, Mo.

19. (a) Nov 19, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19 1939
year 1939 hour 4:30 minute _____ M.

21. I hereby certify that I attended the deceased from Aug 8, 1939, to Nov 19, 1939;
that I last saw h/c no alive on Nov. 17, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia
Myocard stenosis
Due to Pulmonary edema
Branchial pneumonia
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature Dr. J. S. Beck (M. D. or other)
Address 315 Alameda St. Date signed 11-19-39

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, or by.....

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

Signed Norman S Becker

Licensed Embalmer No. 4057

P. O. Address Carrollton, 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.