

Registration District No. _____

Primary Registration District No. 429-4255

Registrar's No. 4203

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Knot Knotter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days 11 mo

3. (a) PRINT FULL NAME

Mary Eliza Powell

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race negro 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lilburn F. Powell 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased October 20 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Johnson County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER { 12. Name Edward Arnold
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Cooper
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Lilburn Powell
(b) Address Knot Knotter, Mo.

17. (a) Burial (b) Date thereof Aug 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Knot Knotter City Cemetery

18. (a) Signature of funeral director C. J. Scullis

(b) Address Knot Knotter Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State D. Missouri (b) County Johnson
(c) City or town Knot Knotter
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29th
year 3 hour 30 minute 30 M.

21. I hereby certify that I attended the deceased from June 1
_____, 1940, (Aug 29), 1940
that I last saw her alive on Aug 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Other Valvular disease

Due to _____ Duration _____

Due to _____ 1 1/2

Other condition Other hepatic
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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

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? 380

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature H. W. Howe (M. D. or other) MD

Address Knot Knotter, Mo Date signed Aug 30 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X21492

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-5-40

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.....

Wendley R. Saults....., Registered Apprentice No. 249
working under my personal supervision.

Signed.....

Licensed Embalmer No. 1086

P. O. Address Knob Noster

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **28868**

Registration District No. **231**

Primary Registration District No. **4263**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Jones Center**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME **Mary Eliza Powell**

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

4. Sex **♀** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **68** Months **10** Days **9**
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (City, town, or county) (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) **Aug 30** (b) **J. A. Koch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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 **G. W. Grove** (M. D. or other) _____

Address **Jones Center Mo** signed _____

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

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

