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FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2906

Registration District No. 401

Primary Registration District No. 5356

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Van Buren Mo.
(c) Name of hospital or institution: Residence 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 yrs years, months or days

8. (a) PRINT FULL NAME Oliver Daniel Powell

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Parrell 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April - 27 - 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Barretton Rural Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
12. Name Olvas Powell
13. Birthplace Jackson Co Mo. 1
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Hunt
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mable T. Powell
(b) Address Lies Summit Mo. P. 2, 2.

17. (a) Burial (b) Date thereof 1-24-1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lies Summit Cem.

18. (a) Signature of funeral director Fields Funeral Home
(b) Address Lies Summit Mo.

19. (a) Jan 23, 1941 (b) Vernie E. Yankee
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Lies Summit Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd
year 1941 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 5, 1941, to Jan 22, 1941
that I last saw him alive on Jan 21, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration _____

Due to Paralysis

Due to _____

Other conditions (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? 363

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

23. Signature John C. Hader (M.D. or other) D.O.
Address Phone Jack Mo Date signed 1/23

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

9388

STATE B. Co. MICHIGAN

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 P. C. Fields

Licensed Embalmer No. 2957

P. O. Address Lees Summit Mo

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.

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

WENA MOORE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 2906

Registration District No. 401

Primary Registration District No. 5356

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Dwan Buren T. P.
(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)

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.

3. (a) PRINT FULL NAME Oliver Daniel Powell

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

19. DATE OF DEATH: Month Jan day 22
year hour minute M.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

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

20. MEDICAL CERTIFICATION

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 myocardial infarction

8. AGE: Years 76 Months 8 Days 25
If less than one day hr min.

Due to paralysis

Due to cerebral hemorrhage

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 92%

Of autopsy

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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) (b)
(Date received local registrar) (Registrar's signature)

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 John C. Sadler (M. D. or other) DO

Address Gene York Date signed

SUPPLEMENTAL

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

