

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Pike  
 (b) City or town Reinsmann  
 (c) Name of hospital or institution: Pike County Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Pike  
 (c) City or town Reinsmann  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 201 N. Carolina  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME RANDOLPH ADAIR 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 Claudine R Powell 6. (c) Age of husband or wife if alive 24 years  
 7. Birth date of deceased 3-3-1916  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 3 day 4 year 41 hour 2 minute any  
 21. I hereby certify that I attended the deceased from 2/28/41 1941 to 3/4 1941  
 that I last saw him alive on 3-4 1941 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

8. AGE: Years 24 Months 25 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace States Mo (City, town, or county) (State or foreign country)  
 10. Usual occupation Bus driver

Due to Cerebral Concussion 4 days  
Tran. Fracture of skull  
 Due to \_\_\_\_\_  
 Other conditions none  
 (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name Robert Powelle  
 13. Birthplace Kansas City Mo (City, town, or county) (State or foreign country)  
 14. Maiden name Nellie Osburn  
 15. Birthplace Pike Co Mo (City, town, or county) (State or foreign country)

Major findings: Fractured skull  
 Of operations \_\_\_\_\_  
 Of autopsy none  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs R. A. Powell  
 (b) Address 201 N. Carolina Louisiana, Mo  
 17. (a) Burial (b) Date thereof 3-6-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Antioch Cemetery  
 18. (a) Signature of funeral director James Stansfield  
 (b) Address Bowling Green, Mo  
 19. (a) 3-6/41 (b) J. H. Haley  
 (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) Accident 057  
 (b) Date of occurrence 2/28/41  
 (c) Where did injury occur? Elsherry Lincoln Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public road  
 (Specify type of place) (e) Means of injury Auto  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address Louisiana, Mo Date signed 3/5/41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17006  
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RECEIVED

District Health Officer No. 10

District File Number 4-41-702

Date Filed APR 10 1941

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 Grace Bonibead

Licensed Embalmer No. 2204

P. O. Address Bowling Green

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11692

Registration District No. 689

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Pepe
- (b) City or town Louisa  
(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) PREVIOUS FULL NAME Randolph Adair Powell
- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

- 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

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

8. AGE:			If less than one day
Years	Months	Days	
<u>25</u>		<u>1</u>	hr. min.

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: (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)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

(Immediate cause of death) Cerebral Con-  
fusion Fract. Skull Duration \_\_\_\_\_

Due to Auto Accident, Car  
Collision with another

Due to car on Highway 79

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) Accident

(b) Date of occurrence 3-28-46

(c) Where did injury occur? Elsherry Lincoln Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
State Highway # 79

While at \_\_\_\_\_ (Specify type of place) (e) Means of injury Auto collision

23. Signature \_\_\_\_\_ (M. D. or other)

Address Journeal, Mo Date signed 6-9-47

SUPPLEMENTAL

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

11692