

FILLED OCT 25 1941

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

31343  
Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 111  
(b) Township P Primary Registration District No. 2411 Registered No. \_\_\_\_\_  
(c) City P (d) Street No. \_\_\_\_\_  
(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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Omer Power

(a) Residence, No. Arbela, Mo. St.  (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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lela Power

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 1, 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
51 1 26

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Employed in  
9. Industry or business in which work was done, as saw mill, bank, etc. Shell loading  
10. Date deceased last worked at this occupation (month and year) Sept 27, 1941 Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arbela, Mo

FATHER  
13. NAME Ruel Power

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arbela Mo.

MOTHER  
15. MAIDEN NAME Rebecca Campbell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arbela, Mo.

17. INFORMANT (ADDRESS) Mrs Rebecca White  
Arbela, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Gorin, Mo. DATE Sept 20, 1941

19. FUNERAL DIRECTOR (ADDRESS) First Baptist  
Memphis, Mo

20. FILED Oct 23, 1941 Chris L Guthrie  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 27, 1941

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 7:30 p.m.

The principal cause of death and related causes of importance were as follows:

died from injuries received from a head-on collision between two automobiles

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? 0 2 25  
(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? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) J. L. M. Council, M. D.  
(Address) Revere Mo Council

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

OCT 24 1948

STATEMENT BY LICENSED EMBALMER

I, George V Roberts, Licensed Embalmer No. 1817

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No: ..... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed George V Roberts

Licensed Embalmer No. 1817

**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.)**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **21343**

Registration District No. **191**

Primary Registration District No. **4114**

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Clark**  
(b) City or town **Luray**  
(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 **Omer Power**  
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 **w**

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

7. Birth date of deceased **Aug 1 1890**  
(Month) (Day) (Year)

8. AGE: Years **51** Months **1** Days **13** (If less than one day min.)

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER

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) **Oct 23-41** (Date received local registrar) (b) **Otis L. Butting** (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 **Sept** day **27**  
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
....., 19.....  
that I have seen him/her alive on....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Received from injuries  
due to head-on collision  
between two automobiles**

Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

Duration

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 with**

(b) Date of occurrence **Sept 27 - 1941**

(c) Where did injury occur? **Public highway**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)

While at work?..... (e) Means of injury

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

Address..... Date signed.....

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

SUPPLEMENTARY

170c  
22

on other car

S-31343 1941