

FILLED NOV 12 1941

Registration District No. 5

Primary Registration District No. 4064

Registrar's No. 19

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Mokane  
(c) Name of hospital or institution none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community .66 years (years, months or days)

3. (a) PRINT FULL NAME JAMES D. POWELL  
3. (b) If veteran, name war no  
3. (c) Social Security No. NONE  
4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Nellie Powell  
6. (c) Age of husband or wife if alive 30 years (Month) (Day) (Year) 1875

8. AGE: Years 66 Months 1 Days 1 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name William A. Powell  
13. Birthplace New Bloomfield, Mo (City, town, or county) (State or foreign country)

14. Maiden name Mary Cheatham  
15. Birthplace New Bloomfield, Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nellie W Powell  
(b) Address Mokane, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3, 1941 (Month) (Day) (Year)  
(c) Place: burial or cremation Mokane

18. (a) Signature of funeral director John Y. Mangin  
(b) Address 700 Cant St, Fulton, Mo

19. (a) Oct 3, 1941 (Date received local registrar) (b) W. D. Williamson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Callaway  
(c) City or town Mokane (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 October day 1st year 1941 hour 10 minute 50 AM.  
21. I hereby certify that I attended the deceased from Oct 1, 1941, to Oct 1, 1941; that I last saw him alive on Oct 1, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions none (Include pregnancy within 8 months of death)

Major findings: Of operations none  
Of autopsy none

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)  
(b) Means of injury \_\_\_\_\_  
28. Signature Frank J. Nichols (M. D. or Chas.)  
Address Mokane, Mo Date signed 10-1-41

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

MARGIN RESERVED FOR BINDING

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.

Aug 30, 1922

3-10-22  
7-11-22

**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..... *Glen G. Manekin* .....  
Licensed Embalmer No. *21725* .....  
P. O. Address..... *Fulton, 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.**