No. 2
-9-4-41
-17-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15413

Registration District No. 773 Primary Registration District No. 4464 Registrar's No. 44

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

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Farmington Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓ 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 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ST FRANCOIS 94

(c) City or town FARMINGTON
(If outside city or town limits, write "RURAL")

(d) Street No. 101 McCORMICK 4 1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME WALTER - POWERS

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex MALE(S)

5. Color or race BLK

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

6. (b) Name of husband or wife Mae Baker

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased 2 (Month) - 28 (Day) - 1883 (Year)

8. AGE:

Years	Months	Days	If less than one day
59	1	26	— hr. — min.

9. Birthplace POCAHONTAS (City, town, or county) 1 ARK. (State or foreign country)

10. Usual occupation LABORER

11. Industry or business —

FATHER
12. Name John POWERS
13. Birthplace ~~[illegible]~~ IRONTON, O Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ARA DUNN
15. Birthplace RALEIGH (City, town, or county) 1 N.C. (State or foreign country)

16. (a) Informant MAE POWERS
(b) Address 101 McCORMICK - FARMINGTON, Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-26-42 (Month) (Day) (Year)
(c) Place: burial or cremation Colored Masonic Farmington, Mo.

18. (a) Signature of funeral director Neidert-Fun-Home
(b) Address FARMINGTON, Mo

19. (a) 4-26-42 (Date received local registrar) (b) Byrdie Buhrmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23 year 1942 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from March 24, 1942, to April 23, 1942 that I last saw him alive on April 22, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Extra-abdominal cancer	1 yr.
Due to	
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature G. L. Wathers (M. D. or other)

Address Farmington Mo. Date signed 4-24

1194

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 541 - 580
Date Filed 5 - 13 - 41

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 Berl J. Miller

Licensed Embalmer No. 8752

P. O. Address Farmington,

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15-413

Registration District No. 773 Primary Registration District No. 4464 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Farmington
(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 10 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois

(c) City or town Farmington
(If outside city or town limits, write "RURAL")

(d) Street No. 101 McCormick
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Walter Powers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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 Feb - 28 - 1883
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 26 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 23
year 1942 hour 1 minute 20 a 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.

	Duration
Immediate cause of death Intra-abdominal Cancer Hodgkin's	1 yr
Due to Origin unknown	
Due to	
Other conditions 55e (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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

23. Signature Geo. R. Watkins (M. D. or other)
Address Farmington Date signed 6-3-42