S. No. 2
—9-4-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 17 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20403

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2643

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1015 East 29th. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 1015 East 29th. St. 8
(If rural, give location) 0
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Agnes May Powers
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: John H. Powers
6. (c) Age of husband or wife if alive: 1870 years
7. Birth date of deceased: Aug. 23 (Month) (Day) (Year)

8. AGE: Years 71 | Months 10 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace: Germany (City, town, or county) (State or foreign country) 4
10. Usual occupation: House wife
11. Industry or business: At Home
MOTHER FATHER
12. Name: William O. Trimble
13. Birthplace: Germany (City, town, or county) (State or foreign country) 4
14. Maiden name: No Record
15. Birthplace: No Record (City, town, or county) (State or foreign country) 1
16. (a) Informant: L. W. Powers
(b) Address: 4925 Euclid
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: July 10, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Atchison, Kansas
18. (a) Signature of funeral director: Mrs. C. L. Forster
(b) Address: 918 Brooklyn
19. (a) 7/10/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1942 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from Coroner, 19____ that I last saw h____ alive on ____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death: Gastric ulcer — Duration
Gastric Hemorrhage
117a
Due to ____
Due to ____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations ____
Of autopsy: See above

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? 3
While at work? ____ (Specify type of place) (e) Means of injury ____
23. Signature: ____ (M. D. or other)
Address: ____ Date signed: 7/10/42

361 (Licensed Embalmer's Statement on Reverse Side)

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 C. H. Wise

Licensed Embalmer No. 2570

P. O. Address Kansas City,

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

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