

41321

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 14 1949

Registration District No. 2009

Primary Registration District No. 3043

Registrar's No. 294

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Elizabeth Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarvia Jane Powers3. (b) If veteran, name war. — 3. (c) Social Security No. —

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Cecil Powers 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased Feb 15th 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 14 If less than one day — hr. — min.9. Birthplace Armstrong County, Penna
(City, town, or county) (State or foreign country)10. Usual occupation House wife11. Industry or business —

MOTHER FATHER
 { 12. Name don't know
 { 13. Birthplace don't know 9
(City, town, or county) (State or foreign country)
 { 14. Maiden name don't know
 { 15. Birthplace don't know 69
(City, town, or county) (State or foreign country)

16. (a) Informant E. E. Waddle(b) Address Monroe City, mo P.F.D. 217. (a) Burial — (b) Date thereof Nov 30 1942
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Jude's Cemetery, monroe, Mo18. (a) Signature of funeral director Wilson & Sons(b) Address Monroe City, mo19. (a) 12-1-42 (b) R. M. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe 69
 (c) City or town Rural 0
(If outside city or town limits, write "RURAL")
 (d) Street No. Monroe City P.F.D. 2
(If rural, give location)
 (e) Citizen of foreign country? — (Yes or No)
 If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 month November day 29
year 1942 hour 8 minute 45 a.m.21. I hereby certify that I attended the deceased from October 25, 1942 to Nov 29, 1942
that I last saw her alive on Nov 28, 1942
and that death occurred on the date and hour stated above.Immediate cause of death CHRONIC Nephritis
Duration 104 yrsDue to —
Due to —Other conditions Fracture of femur 5 yrs
(Include pregnancy within 3 months of death)

PHYSICIAN —
 Major findings: —
 Of operations —
 Of autopsy —
 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) 069
 (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) (c) Means of injury —
 23. Signature John H. Lebb (M. Deacon) —
 Address Monroe City, mo Date signed 1/30/49

(Licensed Embalmer's Statement on Reverse Side)

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

64
69
1 X32873

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 By me.

....., Registered Apprentice No.....
working under my personal supervision.

Signed Leslie L. Nilson

Licensed Embalmer No. 3014

P. O. Address Monroe City 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4-1321
Registrar's No. 294

Registration District No. 209 Primary Registration District No. 304.3

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hambur
(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)

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 _____

3. (a) PRINT FULL NAME Sara Jane Pouch
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov Day 25
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I first saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

Immediate cause of death Chronic Phthisis Duration 1800 days
Due to _____
Due to _____

7. Birth date of deceased Feb 11 (Month) (Day) (Year)
8. AGE: Years 83 Months _____ Days _____ (if less than one day) min. _____

Other conditions Fracture of Femur - 5 weeks
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (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 - fall in Home
(b) Date of occurrence Oct 24, 1942
(c) Where did injury occur? HER HOME MARION MO (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
HER HOME ON FARM (Specify type of place) (or Means of injury fall)
While at work _____
23. Signature J. M. H. H. H. (M. or Recorder)
Address Mount Airy, Mo Date signed 11/31/42

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

SUPPLEMENTARY

MOTHER FATHER

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that this is essential for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the various methods and tools used to collect and analyze data. It highlights the need for consistent data collection procedures and the use of advanced analytical techniques to derive meaningful insights from the data.

3. The third part of the document focuses on the role of technology in data management and analysis. It discusses how modern software solutions can streamline data collection, storage, and analysis processes, thereby improving efficiency and accuracy.

4. The fourth part of the document addresses the challenges associated with data management, such as data quality, security, and privacy. It provides strategies to mitigate these risks and ensure that the data remains reliable and secure throughout its lifecycle.

5. The fifth part of the document concludes by summarizing the key findings and recommendations. It stresses the importance of ongoing monitoring and evaluation to ensure that the data management processes remain effective and aligned with the organization's goals.