V. No. 2
M—5-42
Rev. 5-17-39
1 X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1943

Registration District No. 2309

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3043

41321

State File No.

Registrar's No. 294

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

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
In this community. 30 days
years, months or days)

64
3
48

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

3. (a) PRINT FULL NAME Saria Jane Powers
3. (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. (Month) 15th (Day) 1859 (Year)

8. AGE: Years 83 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Armstrong County (City, town, or county) Penn (State or foreign country)
10. Usual occupation House Wife
11. Industry or business —
12. Name (Father) Don't Know
13. Birthplace Don't Know (City, town, or county) 9 (State or foreign country)
14. Maiden name (Mother) Don't Know
15. Birthplace Don't Know (City, town, or county) 9 (State or foreign country)
16. (a) Informant E. E. Waddle
(b) Address Monroe City, Mo R.F.D. 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 1942 (Month) (Day) (Year)
(c) Place: burial or cremation St Jude Cemetery Monroe City
18. (a) Signature of funeral director. Wilson & Son
(b) Address Monroe City Mo.
19. (a) 12-1-42 (Date received local registrar) (b) R. M. Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29 year 1942 hour 8 minute 45 a.m.
21. I hereby certify that I attended the deceased from October 28, 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.

	Duration
Immediate cause of death CHRONIC Nephritis	10 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Fracture of Femur	5 wks
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) 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) (e) Means of injury
23. Signature John H. Gibbs (M. D.)
Address Monroe City Mo Date signed 11/30/42

(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 By me.

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Leslie L Nelson

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.

S. No. 2B
M—8-21-41
I 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. 4-1321

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 294

1. PLACE OF DEATH:
(a) County: Marion
(b) City or town: Hannibal
(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 years, months or days)
In this community .....

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 Powell
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
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: Feb (Month) 11 (Day) 1858 (Year)
8. AGE: Years 83 Months 4 Days 2 If less than one day: ..... hr. ..... min.
9. Birthplace: (City, town, or county) Penn (State or foreign country)
10. Usual occupation .....
11. Industry or 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) ..... (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 Nov Day 26 year 1942 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw h. alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Nephritis	10 yrs.
Due to: Hd	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Fracture of Femur - Sub	
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): Accident - Fall in Home
(b) Date of occurrence: Oct 24, 1942
(c) Where did injury occur? HER HOME Monroe Mo (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? HER HOME OR FARM (Specify type of place)
While at work? No (c) Means of injury: Fall
23. Signature: J. Ruth Gibbs (M.D.)
Address: Monroe City, Mo Date signed 1/31/43

SUPPLEMENTARY