

4-21  
7-39  
259

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

29 111  
State File No. \_\_\_\_\_  
Registrar's No. 62

FILED AUG 16 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. 593

1. PLACE OF DEATH:

(a) County Putnam  
(b) City or town Powersville *Medicine Day*  
(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 30 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam 86  
(c) City or town Powersville *Medicine Day*  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charlotta May McDowell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife James McDowell 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased May 27, 1889  
(Month) (Day) (Year)

8. AGE: Years 54 Months I Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER { 12. Name James A. Mullin  
13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Polly Ann Osborne  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant James E. McDowell  
(b) Address Powersville Mo.  
17. (a) Burial (b) Date thereof July 9/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Powersville Mo.

18. (a) Signature of funeral director O. O. Brumlee  
(b) Address Lineville Iowa  
19. (a) 7/10/43 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6  
year 1943 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from March 1943 to July 6, 1943  
that I last saw her alive on July 4, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia  
Due to myocardial degeneration  
Due to Mal-nutrition - Dementia  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

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) (Means of injury)  
23. Signature L. W. McDowell (M. D. or other) MD  
Address Powersville, Mo. Date signed 7/9/43

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

10 39

**RECEIVED**

**District Health Officer No. 10**

District File Number 8-43-1293

Date Filed AUG 10 1943

---

---

**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

*Amos L. Greenlee*

Licensed Embalmer No.

3967

P. O. Address

*Lincville Pa*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 241

Primary Registration District No. 5993

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town Pomona  
(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 20 yr.  
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 Charlotte M. McDaniel

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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 M

6. (c) Age of husband or wife if alive 55 years (If deceased, specify date of death)

7. Birth date of deceased May 27 1888  
(Month) (Day) (Year)

8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ (less than one day) min. \_\_\_\_\_

Immediate cause of death: Septicemic Pneumonia  
myocardial degeneration  
renal uraemia  
Albunemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace 20ma  
(City, town, or county) (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 \_\_\_\_\_ (City, town, or county) (State or foreign country)

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature L. M. Daniel (M. D. or other) DO

Address Pomona Date signed \_\_\_\_\_

SUPPLEMENTARY

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

29111