

FILED DEC 17 1943

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 112

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Macon (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Macon County 25 primary (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 years (Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon 61
 (c) City or town New Cambria (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____ 0

3. (a) PRINT FULL NAME GRIFFITH MARION POWELL

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Harah Powell 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 11 1868 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 4 10 _____ hr. _____ min.

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

10. Usual occupation Miller

11. Industry or business _____

MOTHER FATHER
 12. Name Robert Powell
 13. Birthplace Wales 4 (City, town, or county) (State or foreign country)
 14. Maiden name Laura
 15. Birthplace Wales 4 (City, town, or county) (State or foreign country)

16. (a) Informant Addie Powell

(b) Address 5106 Brookside Blvd Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1943 (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria Cemetery

18. (a) Signature of funeral director H. J. Hillland

(b) Address New Cambria Mo

19. (a) 12/17/43 (Date received local registrar) (b) Yvona B. Hunkeler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 1943, to _____, 1943.

that I last saw him alive on Nov 20, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arterio-sclerosis Duration Syn. #

Due to old

Due to _____

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 J. F. Turner (M. D. or other) _____

Address Macon Mo Date signed 12-3-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 12-43-2916

Date Filed DEC 15 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 *O. L. Stephens*

Licensed Embalmer No. 3057

P. O. Address Macon, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 112

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Madison Sup.
(b) City or town Madison Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Madison Co. Infirmary
(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)

3. (a) PRINT FULL NAME Griffith M. Powell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 _____

7. Birth date of deceased July 11 (Month) (Day) (Year)

8. AGE: Years 2 Months 4 Days 1 (If less than one day, min. _____)

9. Birthplace Mo (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 _____ (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) _____ (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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. Immediate cause of death _____

Duration

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-42942