

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34883

State File No.

Registration District No. 237

Primary Registration District No. 5820

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Stanton "Rural"
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home Anderson Hosp
(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 about 18 yrs 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Sidon "Rural" 720
(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 Walter OTTO Powers

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1944 hour 5 minute 9 A.M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Beckie Ann Powers 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Oct-5-1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>-</u>	<u>15</u>	hr. _____ min.

Immediate cause of death Acute Myocardial infarction with coronary artery disease Duration _____

Due to _____

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

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Farming

Major findings: 92a Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name Riley Powers

13. Birthplace Tenn (City, town, or county) (State or foreign country)

14. Maiden name Mary Sherman

15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Beckie Ann Powers

(b) Address Sidon Rural Mo

17. (a) Burial (b) Date thereof Oct-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden

18. (a) Signature of funeral director Landon F. H. Campbell

(b) Address Campana

19. (a) Oct 25 1944 (b) Junda Macom
(Date received local registrar) (Registrar's signature)

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) no

(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? _____

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed Oct 29 1944

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

3C
217
10-44

538

NOV 16 1944

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 Christina M. Landess
Licensed Embalmer No. 4227
P. O. Address Campbell, 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.