

FILED SEP 6 1945

Registration District No. 226

Primary Registration District No. 4482

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Scottland
 (b) City or town Memphis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community Entire Life
 years, months or days)

3. (a) PRINT
FULL NAMEWarren Seth Powell3. (b) If veteran,
name war. 3. (c) Social Security
No. 4-94-20-57004. Sex M5. Color or
race W6. (a) Single, widowed, married,
divorced. married6. (b) Name of husband or wife
Ida H. Powell6. (c) Age of husband or wife if
alive 68 years

7. Birth date of deceased

Jan 41875

(Year)

8. AGE:

70 Years

Months

Days

If less than one day

hr. min.

9. Birthplace

Scottland Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

Retired Farmer

11. Industry or business

12. Name

Wm Powell

13. Birthplace

K. Y.
(City, town, or county) (State or foreign country)

14. Maiden name

Harriet Gray

15. Birthplace

Mo. Co
(City, town, or county) (State or foreign country)

16. (a) Informant

Ida H Powell

(b) Address

Memphis Mo

17. (a) Burial

(b) Date thereof

July 26-45

(Month)

(Day)

(Year)

(c) Place: burial or cremation

Downing Cemetery

18. (a) Signature of funeral director

Bernie Wilson

(b) Address

Memphis Mo19. (a) 8-31-1945
(Date received local registrar)(b) Bernie Wilson
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scottland
 (c) City or town Memphis
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
 year 1945 hour 7 minute 30 a.m.

21. I hereby certify that I attended the deceased from
July 24, 1945 to July 24, 1945
 that I last saw him alive on July 24, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Myocarditis

Due to

Arteriosclerosis

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 sta-
tistically.

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 W. M. Keethler (M.D. or other)Address Memphis, Mo. Date signed 7-25-45

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

1093

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 9-45-1263

Date Filed SEP 5 1945

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.....

Fred Lutz

Licensed Embalmer No. 4256

P. O. Address Memphis

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.