

FILED NOV 8 1945

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 50 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Carthage 1
(If outside city or town limits, write "RURAL")
(d) Street No. 301 No. Maple St. 3
(If rural, give location)
(e) Citizen of foreign country? No 0
(Yes or No)
If yes, name country

3. (a) PRINT FULL NAME George Anderson Powers

3. (b) If veteran, name war Civil War
3. (c) Social Security No. none

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Amanda Caldwell Powers
6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased May 10 1841
(Month) (Day) (Year)

8. AGE: Years 104 Months 5 Days 7
If less than one day hr. min.

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

10. Usual occupation retired farmer

11. Industry or business

MOTHER FATHER {
12. Name unknown
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown 7
15. Birthplace unknown 7
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ellen Vaughn
(b) Address 301 N. Maple, Carthage, Mo.

17. (a) Burial (b) Date thereof Oct, 19, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery
Knell Mortuary

18. (a) Signature of funeral director
(b) Address Carthage, Mo.

19. (a) 10-18-45 (b) J. B. Blanton, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17
year 1945 hour 9:50 minute a M.

21. I hereby certify that I attended the deceased from October 14 1945 to October 17 1945
that I last saw him alive on Oct 17 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Strangled left femoral hernia with gangrenous loop of intestine
Duration 3 days

Due to
Due to

Other conditions extreme old age
(Include pregnancy within 3 months of death)

Major findings: Of operations as above

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 H. E. Boyd, M.D. (M. D. or other)
Address Carthage, Mo. Date signed 10-19-45

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

FEB 14 1947

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.....

Emm R. Kneel

Licensed Embalmer No.....

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P. O. Address.....

Carthage

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.