V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1694 16

Registration District No. 4 13 Primary Registration District No. 5-6-8-2 4292 Registrar's No. 32

1. PLACE OF DEATH:
(a) County: Lincoln
(b) City or town: Winfield Mo
(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 years, months or days) In This Community 23 yr
In this community

2. USUAL RESIDENCE OF DEATH:
(a) State: Missouri (b) County: Lincoln
(c) City or town: ~~Rural~~ Winfield
(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: GERTIE AGNES POWELSON
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: William Powelson
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Jan (Month) 10 (Day) 1897 (Year)
8. AGE: Years 50 Months 0 Days 10 If less than one day hr. min.
9. Birthplace: Moorhead (City, town, or county) Minnesota (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Wm Wilson
13. Birthplace: Houston (City, town, or county) Minnesota (State or foreign country)
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Wm Powelson
(b) Address: Winfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: Anderson Hill Cem
18. (a) Signature of funeral director: Wayne McCoy
(b) Address: Troy Mo
19. (a) 1-22-47 (Date received local registrar) (b) O. J. Heublit (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20 year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Acute Heart
Due to: Disease
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: 0 5 C
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Dr. V. E. Althoff (M. D. or other) DO
Address: Lincoln Co. Center Date signed 1/20/47

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

163 (Licensed Embalmer's Statement on Reverse Side) Troy, Mo. 1/20/47

FEB 13 1964

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 Wayne McCoy

Licensed Embalmer No. 3586

P. O. Address Troy 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.