

FILED FEB 24 1947

Registration District No. **70**

Primary Registration District No. **4298**

Registrar's No. **4**

1. PLACE OF DEATH:
(a) County **LINN**
(b) City or town **LINNEUS**
(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **LINN** **58**
(c) City or town **LINNEUS** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARION POWELL**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Month) (Day) (Year)

7. Birth date of deceased **AUGUST 9 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 5 28 hr. _____ min.

9. Birthplace **LINN COUNTY MISSOURI**
(City, town or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

12. Name **W M F. STONE**

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

14. Maiden name **BATTERS**

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

16. (a) Informant **Mrs Ralph Rinehart**

(b) Address **LINNEUS, MISSOURI**

17. (a) **BORIAL** (b) Date thereof **2-9-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **EMMWOOD CEM.**

18. (a) Signature of funeral director **Sherrill Clark Co.**

(b) Address **LINNEUS, MO. - A. H. Taylor**

19. (a) **Feb. 12 - 47** (b) **Mrs Audie Kelley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEBRUARY** Day **7th**
year **1947** hour **7** minute **9** M.

21. I hereby certify that I attended the deceased from **Jan 1**, 19**47** to **Feb. 5**, 19**47**
that I last saw her alive on **Feb. 5**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinomatosis**

Due to **(primary)**

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 **0**

23. Signature **J. R. Martin** (M. D. or other) _____
Address **BROWNING, MO.** Date signed **2/8-47**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Darr A. Taylor* 433
Licensed Embalmer No. *3761*
P. O. Address *Linneus, 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. March

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH

(a) County Linn
(b) City or town Jennings
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Marion Carvell

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 15 (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days _____ (If less than one day _____ min.)

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

10. Usual occupation clerk

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 Feb year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Primary probably right artery

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

Major findings: Of operations _____ Of autopsy _____ 49A

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.R. Martin (M. D. or other) _____
Address Jennings Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

3-5391