

FILED OCT 10 1947

Registration District No. 374

Primary Registration District No. 4546

1. PLACE OF DEATH:

(c) County Worth
(b) City or town Denver MO
(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 None
In this community 40 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME RHORA REBECCA ANN POWANZ

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 Widowed
(b) Name of husband or wife Louis powanz
6. (c) Age of husband or wife if alive 29 years (Month) (Day) (Year)
7. Birth date of deceased Oct 29 1918 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 20 If less than one day hr. min.

9. Birthplace Henry Co MO (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel Clafangh
13. Birthplace Tenn (City, town, or county) (State or foreign country)

14. Maiden name Mary McNeese
15. Birthplace Tenn (City, town, or county) (State or foreign country)

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

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 21-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Miller Cemetery

18. (a) Signature of funeral director Bram Blas

(b) Address Denver MO

19. (a) Oct 4-1947 (Date received local registrar) (b) Leta E. Dawson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Worth 113
(c) City or town Denver MO (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 Sept day 19 year 1947 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 19 1947 to Sept 19 1947 that I last saw her alive on Sept 19 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver Duration 6 months

Due to.
Due to.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 26
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.
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 2

23. Signature Charles H. Williamson M.D. or other MD
Address Denver MO Date Sept 29-47

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.....

Licensed Embalmer No. *2547*

P. O. Address. *General, Ill.*

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.