

FILED SEP 22 1948

State File No.

Registration District No.

Primary Registration District No. 3043

Registrar's No. 293

1. PLACE OF DEATH:

- (a) County: Maxion
- (b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: 2627 Market 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

3. (a) PRINT FULL NAME: Albert Lee Powell

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

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married

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

7. Birth date of deceased: April 23, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 4 9 hr. min.

9. Birthplace: Bush, MO
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired

11. Industry or business.....

12. Name: George Powell

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

14. Maiden name: S. B. Bell

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

16. (a) Informant: Arthur Powell

(b) Address: 2627 Market, Hannibal Mo

17. (a) Burial (b) Date thereof: 9-2-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Grave new Burial Park

18. (a) Signature of funeral director: James O'Donnell

(b) Address: Hannibal Mo

19. (a) 9-9-48 (b) W. H. M. Ducker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Missouri (b) County: Maxion
- (c) City or town: Hannibal
(If outside city or town limits, write "RURAL")
- (d) Street No.: 2627 Market St
(If rural, give location)
- (e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 1
year: 1948 hour..... minute: 8 P.M.

21. I hereby certify that I attended the deceased from 8-16-48 to 9-1-48, 19.....
that I last saw him alive on 9-1-48, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatosis, generalized

Due to: Cardiac decompensation

Due to:

Other conditions: Arteriosclerosis
(Include prevalence within 6 months of death)

Major findings: Heart disease

Of autops:

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: W. H. M. Ducker (M. D. or other)
Address: Holmes Bldg, Hannibal, Mo Date signed: 9-7-48

Duration: 9
PHYSICIAN: ?
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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 *Michael J. O'Connell*

Licensed Embalmer No. *3246*

P. O. Address *Hannibal 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. oct

Registrar's No. 293

Registration District No. 209

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Albert L. Powell

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased April 23 1948
(Month) (Day) (Year)

8. AGE: Years 66 Months _____ Days _____ If less than one day
 hr. _____ min. _____

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

10. Usual occupation _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____
 year 1948 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 _____

Duration _____

Due to _____

Due to _____

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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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S-30400

OFFICE HOURS
1-1 AND 2-4:30
WEDNESDAY EVENINGS 7-8

OFFICE PHONE 364
RESIDENCE PHONE 1576

H. L. GREENE, M. D.

HOLMES BLDG.
HANNIBAL, MISSOURI

October 2, 1948

Putte

Special Agent, U.S.P.H.S.
Division of Health
Jefferson City, Missouri

Re:

Powell, Albert Mr., Deceased

Dear Sir:

Relative to your request that we state the primary site of cancer of the deceased patient.

I first saw this patient August 16, at which time he was too ill for a complete examination. It is my understanding that Dr. H. B. Norton, of this city, had attended him, and that he had made a diagnosis of tuberculosis. He was sent to Webb City, Missouri, and they returned him to Hannibal in about 30 days, stating that he did not have tuberculosis.

I am sorry that I am unable to give you any further information on this case.

Yours very truly,

enc.

H. L. Greene, M. D.

H. L. Greene, M. D.

