

FILED JAN 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3746**

BIRTH NO. _____ REG. DIST. NO. **337** PRIMARY REG. DIST. NO. **4499** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY SHELBY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MONROE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SHELBYNA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PARIS	
c. LENGTH OF STAY (in this place) 7 Mo.		6 / 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION WASHBORN REST HOME		d. STREET ADDRESS (If rural, give location) E. RUBY ST.	

3. NAME OF DECEASED (Type or Print)	a. (First) SUSAN	b. (Middle) FRANCES	c. (Last) POWELL	4. DATE OF DEATH (Month) (Day) (Year) JAN. 5, 1949
-------------------------------------	-------------------------	----------------------------	-------------------------	---

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) STATE NEVER MARRIED	8. DATE OF BIRTH FEB. 17, 1861	9. AGE (In years last birthday) 87	10 UNDER 1 YEAR Months 10 Days 18	11 UNDER 2 HRS. Hours Min.
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER	10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME JOHN R. POWELL	13b. MOTHER'S MAIDEN NAME MARY VAUGHN	14. NAME OF HUSBAND OR WIFE
--	--	-------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. H. J. BLANTON, PARIS, MO.	ADDRESS
--	-------------------------------------	---	-----------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis -		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephritis - Chronic DUE TO (c) 		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		42	

19a. DATE OF OPERATION ✓	19b. MAJOR FINDINGS OF OPERATION ✓	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ✓	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ✓	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ✓
---	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) ✓	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? ✓
--	--	-------------------------------------

22. I hereby certify that I attended the deceased from **Nov. 13, 1948**, to **Jan 5, 1949**, that I last saw the deceased alive on **Jan. 4, 1949**, and that death occurred at **8 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. L. Caldwell D.O.	23b. ADDRESS SHELBYNA, MO.	23c. DATE SIGNED 1/5/49
---	-----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-6-49	24c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL	24d. LOCATION (City, town, or county) (State) MONROE Co., MO.
---	-------------------------	---	--

DATE REC'D BY LOCAL REG. Jan 11-1949	REGISTRAR'S SIGNATURE Ada Garrison	419	25. FUNERAL DIRECTOR'S SIGNATURE Speed + Blakey	ADDRESS PARIS, MO.
---	---	-----	--	---------------------------

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

JAN 22 1953

RECEIVED

District Health Officer No. 10

District File Number 1-49-16

Date Filed JAN 17 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Missouri

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.