

FILED MAR 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9248

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 3045 Registrar's No. 28

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

67, 2

1. PLACE OF DEATH: a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston	
c. LENGTH OF STAY (in this place) 13 yrs.		d. STREET ADDRESS (If rural, give location) R. 3, Box 330	
d. FULL NAME OF HOSPITAL OR INSTITUTION New Jennings Addition			

3. NAME OF DECEASED a. (First) Henry		b. (Middle) -----		c. (Last) Powell		4. DATE OF DEATH (Month) (Day) (Year) March 14, 1949		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 6, 1882	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 2	IF UNDER 4 HRS. Days 8	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Minister	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Natchez, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Marshall Powell	13b. MOTHER'S MAIDEN NAME Celie Wilson	14. NAME OF HUSBAND OR WIFE Marria Powell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Mrs. Marria Powell	ADDRESS R. 3, Box 330
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 8 mos
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c) -----		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 45⁰			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **11-6-48** to **3-13-**, 19**49**, that I last saw the deceased alive on **3-13-**, 19**49**, and that death occurred at **6:35 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. J. Fingal M.D. U	23b. ADDRESS 204 S. Locust St Charleston, Mo.	23c. DATE SIGNED 3-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 17, 1949	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) Charleston, Missouri
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DATE REC'D BY LOCAL REG. Mar. 19-49 Mrs. Helen Bondura	REGISTRAR'S SIGNATURE 196	25. FUNERAL DIRECTOR'S SIGNATURE F. J. Sparks	ADDRESS Charleston, Mo.
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RECEIVED
District Health Office No. 2,
District File Number 349-414
Date Filed 3-22-49

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 Frank Sparks
.....

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau

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.