

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1696**

BIRTH NO. _____ REG. DIST. NO. **182** PRIMARY REG. DIST. NO. **4298** Registrar's No. **1**

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Linn	
b. CITY (If outside corporate limits, write RURAL and give township) Linn c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) Linn	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED
(Type or Print) **Herman Andrew Powell**

a. (First) **Herman** b. (Middle) **Andrew** c. (Last) **Powell**

4. DATE OF DEATH (Month) (Day) (Year) **Jan 2 1950**

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 2, 1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 3	IF UNDER 2 HRS. Hours -	IF UNDER 15 MIN. Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME **Andrew Powell** 13b. MOTHER'S MAIDEN NAME **Susan Heaton** 14. NAME OF HUSBAND OR WIFE **Margaret**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. **none**

17. INFORMANT'S SIGNATURE OR NAME **Claude Powell, Linn, Mo** ADDRESS **770**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Cerebral hemorrhage** INTERVAL BETWEEN ONSET AND DEATH **3 days**

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) **Hypertension** **10 years**

DUE TO (c) **Arteriosclerosis** **10 years**

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **321X**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. 'AUTOPSY?' YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **Aug**, 1869, to **Jan 1**, 1950, that I last saw the deceased alive on **Jan 1**, 1950, and that death occurred at **6:00 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **W.B. Simpson, D.O.** 23b. ADDRESS **Brookfield, Mo** 23c. DATE SIGNED **1-3-50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **1-4-50** 24c. NAME OF CEMETERY OR CREMATORY **IOOF Cemetery** 24d. LOCATION (City, town, or county) (State) **Linn, Missouri**

DATE REC'D BY LOCAL REG. **Jan 6 - 1950** REGISTRAR'S SIGNATURE **Mrs. Biddie Kelley** 165 25. FUNERAL DIRECTOR'S SIGNATURE **Brookfield Funeral Home** ADDRESS **770**

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

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05-80
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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 W R Wright

Licensed Embalmer No. 4655

P. O. Address Facade - Md.

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.