

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27509  
Registrar's No. 77

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5740

**1. PLACE OF DEATH**  
a. COUNTY: Macon  
b. CITY (If outside corporate limits, write RURAL and give town): Rural-E. Lingo Twp.  
c. LENGTH OF STAY (in this place): 82 years  
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2 miles S. of New Cambria

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).  
a. STATE: Missouri  
b. COUNTY: Macon  
c. CITY (If outside corporate limits, write RURAL and give township): Rural-E. Lingo Twp.  
d. STREET ADDRESS (If rural, give location): 2 miles S. of New Cambria, Mo.

**3. NAME OF DECEASED**  
a. (First): Humphrey  
b. (Middle): Powell  
c. (Last): \_\_\_\_\_  
4. DATE OF DEATH (Month) (Day) (Year): Aug. 16, 1950

**5. SEX:** Male  
**6. COLOR OR RACE:** White  
**7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify):** Married  
**8. DATE OF BIRTH:** Nov. 27, 1859  
**9. AGE (in years last birthday):** 90  
If UNDER 1 YEAR: \_\_\_\_\_  
If UNDER 12 MONTHS: 8 Months 19 Days  
If UNDER 24 HOURS: \_\_\_\_\_

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):** Farming  
**10b. KIND OF BUSINESS OR INDUSTRY:** Farm owner  
**11. BIRTHPLACE (State or foreign country):** Pittston, Penn.  
**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13a. FATHER'S NAME:** Robert Powell  
**13b. MOTHER'S MAIDEN NAME:** Laura Griffith  
**14. NAME OF HUSBAND OR WIFE:** Annie Powell

**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.:** -----  
**17. INFORMANT'S SIGNATURE OR NAME:** Perry Powell  
**ADDRESS:** New Cambria, Mo.

**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.

**MEDICAL CERTIFICATION**  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Age Infirmitates  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) none  
DUE TO (c) none  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
none

**INTERVAL BETWEEN ONSET AND DEATH:** 794 X

**19a. DATE OF OPERATION:** none  
**19b. MAJOR FINDINGS OF OPERATION:** none  
**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 Dec 15, 1848 to Aug 16, 1950, that I last saw the deceased alive on Aug 15, 1950, and that death occurred at 11:20 Am., from the causes and on the date stated above.**

**23a. SIGNATURE (Degree or title):** C. West  
**23b. ADDRESS:** M. D. New Cambria  
**23c. DATE SIGNED:** 8/18/50

**24a. BURIAL, CREMATION, REMOVAL (Specify):** Burial  
**24b. DATE:** Aug. 18, 1950  
**24c. NAME OF CEMETERY OR CREMATORY:** New Cambria Cemetery  
**24d. LOCATION (City, town, or county) (State):** New Cambria, Mo.

**DATE REC'D BY LOCAL REG.:** 8-21-50  
**REGISTRAR'S SIGNATURE:** Josephine King  
**55. FUNERAL DIRECTOR'S SIGNATURE:** W. H. Hill  
**ADDRESS:** New Cambria Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

0610

RECEIVED 8.31.50  
MAGON COUNTY HEALTH DEPARTMENT  
County File No. 9-50-169  
Date Filed 9-2-50

W. J. Hilliard

Date Received: AUG 29 1950  
DISTRICT HEALTH OFFICE #2  
District File Number  
Date Filed

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.

Signed W. J. Hilliard

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.