A 1148—CERTIFICATE OF DEATH, Class 2. (Sanitary Code of Texas, Page 11) TEXAS STANDARD FORM.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Montgomery

City

(No. ..... St.; ..... Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Texas State Board of Health

STANDARD CERTIFICATE OF DEATH

Registered No. 5

25133

2 FULL NAME William Pentecost Powell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE,~~ MARRIED, ~~WIDOWED,~~ OR ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: [redacted] October 12 (Day) 1835 (Year)

7 AGE: 79 yrs. 10 mos. 24 ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Physician & Surgeon
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray B. Wright M.D.
(Address)

15
Filed ....., 191.... .....
REGISTRAR.

MEDICAL PARTICULARS

16 DATE OF DEATH: Nov 6 (Month) 6 (Day) 191 J (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 6, 191 J, to Nov 6 191 J
that I last saw h[redacted] alive on Nov 6 191 J
and that death occurred on the date stated above, at 1 A.m.
The CAUSE OF DEATH was as follows:

Senility 154

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Ray B. Wright M. D.
Nov 6 191 J (Address) Waller Tex

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of injury, and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At Place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 191....

20 UNDERTAKER

ADDRESS

4-10-10M*-2