

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

16382  
 Do not use this space.

791  
1003

REC'D JUN 9 1938

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No.....

(c) City St. Louis (d) Street No. BARNES HOSPITAL Registered No. 4243  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Maudé Mildred Powers 620

(a) Residence, No. 3731 Hartford St St. 16 (If nonresident, give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Tom F. Powers</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>February 27 1938</b>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	50	2	10	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>At Home</b>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Missouri</b>				
FATHER	13. NAME <b>Edward Jackson</b>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Missouri</b>			
MOTHER	15. MAIDEN NAME <b>Miranda Mayfield</b>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Missouri</b>			
17. INFORMANT <b>Tom F. Powers</b> (ADDRESS) <b>3731 Hartford St</b>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Valhalla Cemetery</b> DATE <b>May 10 1938</b>				
19. FUNERAL DIRECTOR (NAME) <b>Peetz Brothers</b> (ADDRESS) <b>3029 Lafayette Ave</b>				
20. FILED <b>MAY - 9 1938</b> <b>J. F. Bredek</b> Local Registrar.				

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/7/38 19

22. I HEREBY CERTIFY, That I attended deceased from 4-22-38, 19, to 5-7-38, 19.

I last saw her alive on 5-7-38, 19. Death is said to have occurred on the date stated above, at 5:10 P.M.

The principal cause of death and related causes of importance were as follows:

**Rheumatic Heart Disease** Date of onset **Mar '38**

**Auricular Thrombosis**

**Cerebral Embolus with hemorrhage**

Other contributory causes of importance:  
**Multiple emboli**

Name of operation none Date of —

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? — Date of injury —, 19  
 Where did injury occur? —  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify —

(Signed) **J. F. Jean**, M. D.  
 (Address) **BARNES HOSPITAL**

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.

Dr J T Jones  
Banner Hospital

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *J T Jones*

Licensed Embalmer No. *21245*

P. O. Address *St Louis 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, above space should be left blank.**