DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAR 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8086

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 296

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

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Clayton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days) In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town W. Walnut Manor (If outside city or town limits, write "RURAL")
(d) Street No. 7024 Beulah (If rural, give location)
(e) If foreign born, how long in U. S. A.? / years.

3. (a) PRINT FULL NAME Edward E. Powell
3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown
4. Sex male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary Powell
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Nov. 25 1871 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
69	2	12	hr. min.

9. Birthplace Trenton, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation printer
11. Industry or business unemployed at present
FATHER 12. Name Joseph Powell
FATHER 13. Birthplace Unknown / Ky. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Beal
MOTHER 15. Birthplace Unknown / Penn. (City, town, or county) (State or foreign country)
16. (a) Informant Mary Powell
(b) Address 7024 Beulah Place
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.
18. (a) Signature of funeral director Gerard Carroll
(b) Address 4600 Gravois
19. (a) FEB 7 1941 (Date received local registrar) (b) R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day Feb. year 1941 hour 9 minute 45 p. M.
21. I hereby certify that I attended the deceased from 1-25-41, 19..., to 2-6-41, 19...; that I last saw him alive on 2-6-41, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	3 days
Due to Myocarditis	2 wks
Due to Gastro intestinal Hemorrhage and Secondary Anemia	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature John D. Matthews (M. D. or other) D
Address St. Louis Co. Hosp. Date signed 2/7/41

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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Registration District No. 784 Primary Registration District No. 101 Registrar's No. 296

1. PLACE OF DEATH

(a) County St Louis

(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edw E. Jowell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure — Duration

Due to Myocarditis

Due to Gastro Intestinal Hemorrhage and

Due to Secondary anemia

Other conditions Cause of the hemorrhage unknown; see (Include pregnancy within 3 months of death)

Major findings: Postmortem

Of operations 9 3 6

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature John G Marchase (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

SUPPLEMENTAL

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

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.