

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15509
Registrar's No. 955

Registration District No. 1945

Primary Registration District No. 3.063

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton Twp.
(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 NONE
(Specify whether years, months or days) NONE

3. (a) PRINT FULL NAME Annie Rachel Powell
3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles C. 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased Aug. 1 1917
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 8 18 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name John Brookshier
13. Birthplace Montgomery City Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Ora Naughton
15. Birthplace Bluffton Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Brookshier
(b) Address 307 Antelope, St. Louis

17. (a) Burial (b) Date thereof April 24-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WELLSVILLE MO.

18. (a) Signature of funeral director Diedrich Funeral Home
(b) Address 8319 Hall's Ferry Rd.

19. (a) 4-22-43 (b) C. D. MO Laramy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town Augusta
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1943 hour 2 minute A 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 While riding as a passenger in an automobile driven by her husband that Due to: collided with a bridge.

Due to Multiple fractures, lacerations, abrasions and contusions;

Other conditions Ruptured liver; Subdural and subarachnoid hemorrhage;

Major findings: Hemoperitoneum; Hemorrhage in lungs; Odor of alcohol in gastric contents.
Of autopsy Yes.

Duration
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) Accident.

(b) Date of occurrence April 19, 1943

(c) Where did injury occur? St. Cyr & Bellefontaine Rd.
(City or town) (County) (State)

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

While at work? (Specify type of place) (e) Means of injury ?

23. Signature Christ Rep. Lerner (M.D. or other)
Address Kirkwood, Mo. 4-29-43 Date signed

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.....

John M Meyer

Licensed Embalmer No. *3788*

P. O. Address: *Kirkwood, 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.