

V. S. No. 2
DOM-8-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26516

State File No.

FILED SEP 8 1944 318

Registration District No. Primary Registration District No.

Registrar's No. 7208 ✓

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

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

(d) Street No. 8739 Partridge Ave.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MARGARET CATHERINE POWERS

(b) If veteran, name war.....

(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..... Edward Powers

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased February 24 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

44 5 27 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Michael J. Powers

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

14. Maiden name Anna Larkin

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

16. (a) Informant Edward Powers

(b) Address 8739 Partridge Ave.

17. (a) Burial (b) Date thereof 8/24/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) AUG 22 1944 (Date received local registrar)

J. F. Braden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21st
year 1944 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from August 12th 1944 to August 21, 1944
that I last saw her alive on August 21st, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myelogenous leukemia

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy none

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature M. L. Abney (M. D. or other)

Address BARNES HOSPITAL Date signed 8/21/44

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

(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.....

Sheldon Collier

Licensed Embalmer No.....

3382

P. O. Address.....

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.