

FILED JUN 11 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2327

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Months
In this community 48 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3921 Park
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Ned L. Powers

3. (b) If veteran, name war No

3. (c) Social Security No. 495-09-1950

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Margaret Powers

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May 4 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 0 Days 25
If less than one day hr. min.

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

10. Usual occupation Cigar Store, Owner

11. Industry or business

12. Name Stephen J Powers

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

14. Maiden name Dora Ellen Curtis

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Margaret Powers

(b) Address 3921 Park

17. (a) Burial Date thereof 5/31/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Dwight E. Robin Co

(b) Address 20 West Linwood

19. (a) 5-30-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1945 hour 10 minute 0 M.

21. I hereby certify that I attended the deceased from Pathologist, 19...
that I last saw him alive on May 29, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the face
(Origin not known)

Due to...
Due to...

Other conditions 53
(Include pregnancy within 3 months of death)

Major findings:
Of operations...
Of autopsy As above

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...
Signature braine Sherwood (M. D. or other)
Address Pathologist Date signed...

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Charles M. Quinn

Licensed Embalmer No.....

3944

P. O. Address.....

K.E. 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.