

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **793**

**FILED FEB 1 1946**  
Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **568**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**5876 Cates Ave. /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

**Charles H. Powell**

3. (b) If veteran, name war **Yes (World 1)**

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 **Thelma Powell**  
6. (c) Age of husband or wife if alive **45** years  
7. Birth date of deceased **Oct. 21st., 1899**  
(Month) (Day) (Year)

8. AGE: Years **46** Months **2** Days **25** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **Mfgs. Agent**

11. Industry or business **Charles H. Powell**

12. Name **Charles H. Powell**  
13. Birthplace **Mo. n**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Annette Hereford**  
15. Birthplace **Mo. n**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Thelma Powell**

(b) Address **5876 Cates Ave.**  
17. (a) **Burial** (b) Date thereof **1-18-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Russell**  
(b) Address **3840 Lindell Blvd.**

19. (a) **JAN 18 1946** (b) **J. P. Breck**  
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5876 Cates Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **16**  
year **1946** hour **5** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Aug 17**, 19**45**, to **Jan 16**, 19**46**, that I last saw him alive on **Jan 14**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the Lung**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Carcinoma of the Lung**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

**6 Months**

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature **Paul Murphy** (M.D. or owner)  
Address **539 N Grand** Date signed **1-17-46**

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

2984

01  
Murphy  
Humboldt Bldg.

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**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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Lincoln

**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.**