

No. 2
OM-5-43
v. 5-17-39
I X36671

FILED MAR 31 1946
Registration District No. _____

Primary Registration District No. **1003**

10452
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

(d) Length of stay: In hospital or institution 32 yrs. 3 mos. 2 ds.
(Specify whether _____)

In this community 68 yrs.
years, months or days)

3. (a) PRINT FULL NAME ANNIE POWERS

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 7 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>9</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Ray Powers

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

{ 14. Maiden name Margaret Powers

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

16. (a) Informant T. Angler

(b) Address 5400 Arsenal St.

17. (a) BURIAL (b) Date thereof 2-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Carl W. Kelly

(b) Address 7386 Lindell

19. (a) MAR 14 1946 (b) J. F. Breach
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
13

(d) Street No. 5400 Arsenal St. (If rural, give location) 0

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
year 1946 hour 6.20 minute 00 P. M.

21. I hereby certify that I attended the deceased from 15 _____, 1946 to Mar. 12 _____, 1946
that I last saw her alive on Mar. 12 _____, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease 6 yrs.

Schezophrenia 35 yrs.

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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) _____ means of injury _____

23. Signature Jack R. Delman (M. D. or other) _____

Address 5400 Arsenal Date signed 3/13/46

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 Howard G. Rowland

Licensed Embalmer No. 2114

P.O. Address. Thomas & 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.