

**FILED JUN 6 1946**  
**318**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **4234**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (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 Infirmary**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **11/29/45 to 5/30/46**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Powell, Albert**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Mamie Mills Powell** 6. (c) Age of husband or wife if alive **44** years  
 7. Birth date of deceased **May 7 1886**  
(Month) (Day) (Year)

8. AGE: Years **60** Months **0** Days **23** If less than one day **9 hr. 45 min.**

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

10. Usual occupation **R. R. Porter**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **John Powell**  
 13. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Tissie Powell**  
 15. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmary Records**

(b) Address **5800 Arsenal**

17. (a) **Removal** (b) Date thereof **MAY 31 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT VERNON 9ND**

18. (a) Signature of funeral director **Porter Funeral Home**

(b) Address **3028 DICKSON ST**

19. (a) **MAY 31 1946** (b) **J. F. Bredeck**  
(Date received local registrar) (Registrar's signature)

**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. **4337 Cook Ave.**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **May** day **30**  
 year **1946** hour **9** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **November 29 1945** to **May 30 1946**  
 that I last saw him alive on **May 30 1946**  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **General Paresis, known Luetic** **1945**

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)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature **Dr. Vernon Powell** (M. D. or other) \_\_\_\_\_  
 Address **5800 Arsenal** Date signed **5-30-46**

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

9/26/81 8  
TMR

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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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard Ave.

**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.**