DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40795

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5522

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: K.C.General Hospital No.1 O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 4 years
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. 3006 East 37th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Powers
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex M O
5. Color or race W
6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widower
6. (b) Name ~~of husband~~ or wife O
Amanda Jane Powers
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Apr - 5 - 1857 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
89	8	26	hr. min.

9. Birthplace Leavenworth to Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business Cattle Business
FATHER
12. Name David W. Powers
13. Birthplace Not Known (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) (State or foreign country) 9
16. (a) Informant John W. Roberts
(b) Address 5014 Webster
17. (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 1-2-1947 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Mt. Muncie Cemetery
18. (a) Signature of funeral director Gibson & Son
(b) Address Kansas City Kansas
19. (a) 12-31-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31st year 1946 hour 5 minute 25 A. M.
21. I hereby certify that I attended the deceased from 12-27-46, 19 to 12-31-46, 19; that I last saw him alive on 12-31-46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
generalized arteriosclerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 97	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury O
23. Signature Wm W. Hart (M. D. or other) MD
Address Med.Dir.K.C.Gen.Hospital Date signed 12-31-46

(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 George M. Mallo

Licensed Embalmer No. 2798

P. O. Address K. C. Kansa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.