

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1283
Registrar's No. 396

FILED FEB 11 1947

Registration District No. 1002 Primary Registration District No. 1002

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: 4334 Indiana
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether years, months or days)
In this community 20 years

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. 4334 Indiana
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph POWELL

3. (b) If veteran, name war World War I 3. (c) Social Security No. none

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Helen Louise Powell
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased October 7, 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 3 17 hr. min.

9. Birthplace Rozellville Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Railway Mail Clerk

11. Industry or business K. C. Terminal

12. Name John Powell

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

14. Maiden name Susanna Reif
15. Birthplace Rotesmills Wisconsin
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helen L. Powell

(b) Address 4334 Indiana, K. C., Mo.

17. (a) Burial (b) Date thereof 1-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Melody-McGilley-Eylar
(b) Address Kansas City, Missouri

19. (a) 1-27-47 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24
year 1947 hour 1 minute 05 P.M.

21. I hereby certify that I attended the deceased from Oct. 5, 46
1946, to Jan 24, 1947
that I last saw him alive on Jan 24, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Due to Carcinoma of the Rectum
Due to Melastatin Ca of Liver
Other conditions (Include pregnancy within 3 months of death) _____

Duration

2 days
1 yr

Major findings: 462
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? _____

While at work? (Specify type of place) _____
(e) Means of injury _____
23. Signature Leo M. Muller (M. D. or other) M.D.
Address 3548 Indiana Date signed Jan 24-47

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

MOTHER FATHER

FEB 19 1947

MAR 25 1947

Li 9717
Dr. Geo. W. Sullivan
3548 S. Indiana
Apt. 205 East
Xi. 5411

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 *J. H. [Signature]*

Licensed Embalmer No. 2999

P. O. Address.....

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.