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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 22 1947
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. **40074**
Registrar's No. **10323**

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

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:
St. Luke's Hospital
(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 KATIE POWERS
3. (b) If veteran, name war..... None
3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Sidney Powers
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased April 11, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 6 25 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name William Clark

13. Birthplace Marshall County, Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Patama Bowerman

15. Birthplace Marshall County, Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Omer H. Powers

(b) Address 1232 Hodiamont Avenue

17. (a) Burial (b) Date thereof Nov 10, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Shepard Funeral Home
1167 Hamilton Avenue.

(b) Address
19. (a) NOV 8 - 1947 J. F. Brodeur
(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. 1232 Hodiamont Avenue
5 - (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6, 1947
year 7 hour 45 minute P M.

21. I hereby certify that I attended the deceased from Aug 1
1946 to Nov 7, 1947
that I last saw her alive on Nov 7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death myelogenous leukemia
Due to.....
Due to.....

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

Major findings:
Of operations.....
Of autopsy.....

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 J. F. Brodeur (M. D. or other)
Address 4423 Delmar Date signed Nov 7/47

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. Allen Hayes Jr.*
Licensed Embalmer No. *4053*
P. O. Address..... *St. Louis*

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.