S. No. 300
M—10-47
v. 5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 19 1948
Registration District No. 149

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 19622
Registrar's No. 2479

**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:
401 E. ARMOUR
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 25 YRS.
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO. (b) County JACKSON
(c) City or town KANSAS CITY, MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 401 E. ARMOUR
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

48
3
8
0

3. (a) PRINT FULL NAME MRS. NORA E. POWELL

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife DR. B. S. POWELL

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased AUG. (Month) 2 (Day) 1881 (Year)

8. AGE: Years 66 Months 10 Days 8 If less than one day hr. min.

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

10. Usual occupation HOME

11. Industry or business

FATHER
12. Name J. C. HENSON
13. Birthplace ILL. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name SARAH MASTIN
15. Birthplace ILL. (City, town, or county) (State or foreign country)

16. (a) Informant DR. B. S. POWELL
(b) Address 401 E. ARMOUR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-12-48 (Month) (Day) (Year)
(c) Place: burial or cremation LIBERTY, MO.

18. (a) Signature of funeral director STINE & MCCLURE
(b) Address KANSAS CITY, MO.

19. (a) 6-12-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JUNE day 10
year 1948 hour 12 minute 00 P M.

21. I hereby certify that I attended the deceased from June 1-48, 19 , to June 10, 1948
that I last saw her alive on June 7, 1948
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| Due to | |
| Due to Arteriosclerosis | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 83 | |
| 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

23. Signature C D Cantrell (M. D. or other)
Address 636 Argyle Blvd Date signed 6/10/48

(Licensed Embalmer's Statement on Reverse Side)

Dr Cantrell
Oxygen Body
11 a.m.

**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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address K.C. 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.**