

FEDERAL BUREAU OF INVESTIGATION
DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

29926

State File No. _____
Registrar's No. 3656

Registration District No. 149

Primary Registration District No. 1002

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

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 ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 hrs.
In this community 17 yr. 13 hrs. (Specify whether 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. 3410 So BENTON
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME SHARON KAY POWERS
3. (b) If veteran, name war No
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month 9th day 6th
year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 9-6, 1948, to date, 1948
that I last saw h. _____ alive on 9-6, 1948
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) 0 single widowed, married, divorced CHILD
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased, September 6-1948
(Month) (Day) (Year)

Immediate cause of death Amputation Duration 1 day
Due to prematurity - tetanus (6 hrs)
Due to infection

8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hr. min.

9. Birthplace KANSAS CITY MISSOURIA
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name MILK L. POWERS
13. Birthplace HARDFORD CITY INDIANA
(City, town, or county) (State or foreign country)
14. Maiden name LESLIE RUTH PINNER
15. Birthplace SHAWNEE OKLAHOMA
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 159
1. Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Milo L. Powers

(b) Address 3410 So Benton

17. (a) Burial (burial, cremation, or removal) (b) Date thereof 9-7-48
(Monthly) (Day) (Year)

(c) Place: burial or cremation Shawnee, Okla

18. (a) Signature of funeral director D. W. Williams
(b) Address 1401 Brush Creek Blvd

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? _____

19. (a) 9-7-48 (Date received local registrar) (b) Geraldine Homes (Registrar's signature)

While at work _____ (Specify type of place)
(e) Means of injury 0
23. Signature G. Williams (M. D. or other) _____
Address St. Joseph's Hospital Date signed 9/6/48

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 Ray

Licensed Embalmer No. 4182

P. O. Address Kansas City, 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.