

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28561
Registrar's No. 6655

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
		d. STREET ADDRESS (If rural, give location) 5657 Theodosia Ave.,	

3. NAME OF DECEASED (Type or Print) JAMES POWERS			4. DATE OF DEATH (Month) (Day) (Year) Aug. 2, 1950.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 13, 1871.	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Policeman	11. BIRTHPLACE (State or foreign country) Ironton, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME James Powers	13b. MOTHER'S MAIDEN NAME Elizabeth Burges	14. NAME OF HUSBAND OR WIFE Anna Powers
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15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 493-24-8474	17. INFORMANT'S SIGNATURE OR NAME Anna Powers, 5657 Theodosia Ave.,	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho Pneumonia		MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH 7 days
	ANTECEDENT CAUSES (b) _____			
	DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fr Femoral neck nailed				

19a. DATE OF OPERATION 7-18-50	19b. MAJOR FINDINGS OF OPERATION 8 days previous to onset	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMEHIDE Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In church	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 69036
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 11, 1950	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall
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22. I hereby certify that I attended the deceased from 7-16, 1950, to 8-1, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred 10:45 P.M. from the causes and on the date stated above.

23a. SIGNATURE C.A. Stone (Degree or title) M.D.	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 8-4-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 7, 1950.	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. AUG 4 1950 REG.	REGISTRAR'S SIGNATURE J. W. Clark	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark, 1125 Hodiamont Ave.,	ADDRESS
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

Dr. C.A. Stone,
3720 Washington Blvd.,
JE. 6505 1-30--4, P.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 me

working under my personal supervision.

Student Embalmer No.

Signed

William S. Laffey

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address W. Charles, Jr.

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.