

FILED SEP 22 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31766

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8081

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2119	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET (If rural, give location) ADDRESS 11 4223 <sup>W</sup> FINNEY	

3. NAME OF DECEASED (Type or Print)	a. (First) Oscar	b. (Middle) —	c. (Last) Powell	4. DATE OF DEATH (Month) (Day) (Year) Sept. 11 1951
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5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-24, 1910	9. AGE (In years last birthday) 41 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILLING STATION HELPER	11. BIRTHPLACE (State or foreign country) NEWPORT ARK. 1	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME FRED POWELL	13b. MOTHER'S MAIDEN NAME MAGNOLIA WALKER	14. NAME OF HUSBAND OR WIFE ALBERTA POWELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alberta Powell 4223 <sup>W</sup> FINNEY

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrostatic Pneumonia and Ascites Pleural Effusion		INTERVAL BETWEEN ONSET AND DEATH 18 hrs
	ANTECEDENT CAUSES DUE TO (b) Carcinoma of Larynx		
	DUE TO (c) Undetermined		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Metastasis of Carcinoma of			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Larynx and Generalized Carcinomatosis of Abdomen.	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 161X

22. I hereby certify that I attended the deceased from 9-9, 19 51 to 9-11, 19 51, that I last saw the deceased alive on 9-11, 19 51, and that death occurred at 7:30a m., from the causes and on the date stated above.

23a. SIGNATURE H. Mark E. Woodson, D.O.	(Degree or title)	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 9-11-51
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 9-15-51	24c. NAME OF CEMETERY OR CREMATORY NEWPORT	24d. LOCATION (City, town, or county) (State) NEWPORT ARK

DATE REC'D BY LOCAL REG. SEP 12 1951	REGISTRAR'S SIGNATURE Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE AF. WALTON	ADDRESS 2707 STODDARD ST.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Arthur D. Heileard*

Licensed Embalmer No. *4221*

P. O. Address *4740 - Cupper Rd*

**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.