

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4447**

**FILED JAN 26 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **3**

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Slater</b>	c. LENGTH OF STAY (in this place) <b>50 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Slater</b> <b>0971</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>none</b>		d. STREET ADDRESS (If rural, give location) <b>634 N. Central</b> <b>0</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b>	b. (Middle) <b>Edward</b>	c. (Last) <b>Powers</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 22-1953</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 27th, 1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired locomotive engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>engineer</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>83</b> Months <b>4</b> Days <b>25</b> Hours <b>Min.</b>
11. BIRTHPLACE (State or foreign country) <b>Grand Rapids, Mich.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S</b>

13a. FATHER'S NAME <b>Michael Powers</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Morarity</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret Powrs.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>710-05-6115</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Margaret Powers</b>	ADDRESS <b>Slater, Mo.</b>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>None</b> DUE TO (c) <b>None</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b> <b>491X</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Jan 16, 1953** to **Jan 22, 1953**, that I last saw the deceased alive on **Jan 21, 1953**, and that death occurred at **6:50 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>[Signature]</i>	23b. ADDRESS <b>215 N. Main St. Slater, Mo.</b>	23c. DATE SIGNED <b>Jan 22. 53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1/24/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Slater, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>1/22/53</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS <b>Slater, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 10 1953

MAR 24 1958

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

*Sam M. Hill*

Licensed Embalmer No.

*1292*

P. O. Address

*State me*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

*13578 13.14*