

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13547**

20669
FILED MAY 6 1953

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **65**

191
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: rank: before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY OR TOWN Harrisonville		c. CITY OR TOWN Belton	
c. LENGTH OF STAY (In this place) 5 minutes		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print) RONALD CLIFFORD POWELL			4. DATE OF DEATH (Month) (Day) (Year) April 27 1953		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Apr 27-1951		9. AGE (In years last birthday) 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Harrisonville Mo		12. CITIZEN OF WHAT COUNTRY USA		

13a. FATHER'S NAME William James Powell		13b. MOTHER'S MAIDEN NAME Patricia Cecilia Phelps		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME R. J. Powell ADDRESS Belton Mo			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Stenosis		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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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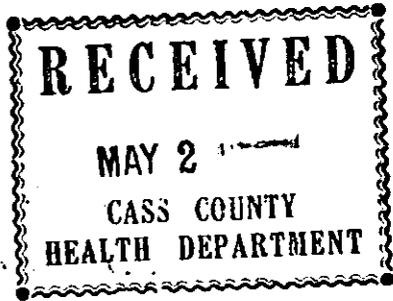
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **4-27-1953**, to **4-27-1953**, that I last saw the deceased alive on **4-27-1953**, and that death occurred at **12:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edward S. Jones, M.D.	23b. ADDRESS Harrisonville, Mo	23c. DATE SIGNED 4-27-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr 27-1953	24c. NAME OF CEMETERY OR CREMATORY Crest Cemetery	24d. LOCATION (City, town, or county) (State) Harrisonville Mo
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DATE REC'D BY LOCAL REG. Apr 27 1953	REGISTRAR'S SIGNATURE Dora Barward	25. FUNERAL DIRECTOR'S SIGNATURE Rehnbuys's ADDRESS Harrisonville Mo
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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

Infant - not embalmed

Signed *Ernest R. Remminger*

Licensed Embalmer No. *3368*

P. O. Address *Harrisonville 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.