

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**15000**

State File No. \_\_\_\_\_

ED MAY 2 1953

BIRTH NO. 23127 REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 161

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Marion</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>	
c. LENGTH OF STAY (in this place) <u>50 min.</u>		d. STREET ADDRESS (If rural, give location) <u>1119 Sierra Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>			

<b>3. NAME OF DECEASED</b> (Type or Print) <u>Unnamed Baby Powell</u>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 24, 1953</u>		
a. (First)		b. (Middle)		c. (Last)	

<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>April 24, 1953</u>	<b>9. AGE</b> (In years last birthday) <u>0</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>50</u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Hannibal, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
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<b>13a. FATHER'S NAME</b> <u>Unknown</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Ruth Powell</u>	<b>14. NAME OF HUSBAND OR WIFE</b> -----
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Mrs Ruth Powell</u>	<b>ADDRESS</b> <u>Hannibal, Mo.</u>
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<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Prematurely Asphyxiated</u>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>6 mo gestation</u> DUE TO (c) _____		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>776X</u>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <u>Tom Carroll</u>	(Degree or title) <u>0</u>	<b>23b. ADDRESS</b> <u>707 Parkway</u>	<b>23c. DATE SIGNED</b> <u>4/22/53</u>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>April 25, 1953</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Hope Cemetery</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Hannibal, Missouri</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>4-25-53</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Dr. E. M. Lucke</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>By W. E. Fisher</u>	<b>ADDRESS</b> <u>Jacks Schwartz - Hannibal, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

44  
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**RECEIVED** MAY 1 1953  
**MARION CO. HEALTH DEPT.**  
**DATE FILED** MAY 1 1953

**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 Jack Schwartz  
Licensed Embalmer No. 4900

P. O. Address Hannibal, 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.