

FILED MAY 18 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19778

State File No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

4579

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) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		26 STREET ADDRESS 1209 Howard St		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Beatrice Richardson Powers			4. DATE OF DEATH 5 3 53		
5. SEX F M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 8-11-1900		9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR 8 Months 22 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Faithville, Arkansas	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Shird Richardson Tobac		13b. MOTHER'S MAIDEN NAME Plus	
14. NAME OF HUSBAND OR WIFE Joseph Powers		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. 281-12-9403	
17. INFORMANT'S SIGNATURE OR NAME Lester Blaszynski		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) Pulmonary Congestion Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) Coronary Occlusion II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201	
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 3:18 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Patrick E. Taylor		23b. ADDRESS Cassner 1300 Clark		23c. DATE SIGNED 5-5-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-6-53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem	
24d. LOCATION (City, town, or county) St. Louis County, mo.		DATE REC'D BY LOCAL REG. MAY 5 1953		REGISTRAR'S SIGNATURE J. C. Smith	
FUNKEL DIRECTOR'S SIGNATURE		ADDRESS		25. FUNKEL DIRECTOR'S SIGNATURE ADDRESS	

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....

Licensed Embalmer No. *1374*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.