

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5704**

BIRTH NO. **FILED MAR 9 1954** REG. DIST. NO. **275** PRIMARY REG. DIST. NO. **3053** Registrar's No. **36**

812
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) Rolla		c. CITY (If outside corporate limits, write RURAL and give township) Irondale 1100	
d. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) ALBERT	b. (Middle) JACKSON	c. (Last) POWELL	4. DATE OF DEATH (Month) (Day) (Year) Feb. 26 1954
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 26 1872	9. AGE (In years last birthday) 81	10. UNDER 1 YEAR 9 Months 1 Days	11. UNDER 12 HRS. 1 Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Chester Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Benjamin Powell	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Ilola L. Powell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME William Powell, Fredericktown Mo. ADDRESS
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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 4 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic heart disease		
	ANTECEDENT CAUSES Morbid 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. sanility prostatic disease			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4200	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 **2-18 1954** to **2-26 1954**, that I last saw the deceased alive on **2-23 1954** and that death occurred at **6:00P** m., from the causes and on the date stated above.

23a. SIGNATURE E. E. Feind m.d. (Degree or title)	23b. ADDRESS Rolla mo.	23c. DATE SIGNED 3-4-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3-2-54	24c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	24d. LOCATION (City, town, or county) (State) Caledonia Mo.
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DATE REC'D BY LOCAL REG. Mar 4 1954	REGISTRAR'S SIGNATURE Nadine L. Stoeck 380	25. FUNERAL DIRECTOR'S SIGNATURE Subell White ADDRESS 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.

Signed S. L. V. [Signature]

Student _____
Student Embalmer

Licensed Embalmer No. 3394

P. O. Address Rolla 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.