

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25104**
Registrar's No. **6291**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 33 Years	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: Missouri Baptist Hospital			
e. STREET ADDRESS 4035 N. Taylor Avenue, 15²¹⁰		(If rural, give location)	

3. NAME OF DECEASED (Type or Print) MATTIE POWERS			4. DATE OF DEATH July 11th, 1954
a. (First)	b. (Middle)	c. (Last)	(Month) (Day) (Year)

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 5th, 1896	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 2 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (City and State or Foreign Country) Russell, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Burton Keeler		13b. MOTHER'S MAIDEN NAME Jennie Barnes		14. NAME OF HUSBAND OR WIFE Edwin Lawrence Powers	
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mr. Edwin L. Powers, 4035 N. Taylor Avenue	ADDRESS
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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 18 months
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypernephroma of left kidney		DUPLICATE (b) c. Metastases		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUPLICATE (c)		

19a. DATE OF OPERATION 2/7/53	19b. MAJOR FINDINGS OF OPERATION As above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 18 DX
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22. I hereby certify that I attended the deceased from **March 7, 1952**, to **July 11, 1954**, that I last saw the deceased alive on **July 10, 1954**, and that death occurred at **7:35P m.**, from the causes and on the date stated above.

23a. SIGNATURE Donald E. Kelker	(Degree or title) M.D.	23b. ADDRESS 3121 N. Grand St. Union, Mo.	23c. DATE SIGNED 7/12/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/14/54	24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	24d. LOCATION (City, town, or county) (State) Saint Louis, Missouri
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DATE REC'D BY LOCAL REG. JUL 12 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE CALVIN F. FRUTZ	ADDRESS 4828 Natural Bridge Blvd., St. Louis, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Hours 2:00PM to 6:00PM
Monday.

File in City

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 *John A. Mlinar*.....

Licensed Embalmer No. *4189*

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.