

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39124**

Registrar's No. **10271**

FILED NOV 22 1954

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

No. 300
10.48

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10271	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		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 St. Louis City Hospital				STREET ADDRESS (If rural, give location) 3249 Lafayette Ave. 2179			
3. NAME OF DECEASED (Type or Print) a. (First) HATTIE (Harriet)		b. (Middle) _____		c. (Last) POWELL		4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 7/29/1879	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Mohan			13b. MOTHER'S MAIDEN NAME Nellie Worsley			14. NAME OF HUSBAND OR WIFE James P. Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James T. Powell 3249 Lafayette			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of breast with generalized metastases. INTERVAL BETWEEN ONSET AND DEATH _____ 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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21f. HOW DID INJURY OCCUR 170X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 6-18-54 , 19____, to 11-10-54 , 19____, that I last saw the deceased alive on 11-10-54 , 19____, and that death occurred at 11:50 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) James H. Powell, MD				23b. ADDRESS 1515 LAFAYETTE		23c. DATE SIGNED 11-10-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/31/54		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. NOV 12 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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 *Joseph Vollema*.....
Licensed Embalmer No. *4014*.....
P. O. Address *3125 [unclear]*.....

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.