

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED JAN 17 1955

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>31</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> <input type="radio"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>1 hour</u>		c. CITY OR TOWN <u>Trimble</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Missouri Methodist Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Route #1</u> <u>0250</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GEORGE</u>		b. (Middle) <u>W.</u>		c. (Last) <u>POWELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 10, 1955</u>	
5. SEX <u>Male</u> <input type="radio"/>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1874</u>	
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 MTH. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James Powell</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Fertig</u>			14. NAME OF HUSBAND OR WIFE <u>Ida Mae Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>M. C. Powell, Trimble, Missouri</u>			
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.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage of Prostate</u> 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.					INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
19a. DATE OF OPERATION <u>Jan 4, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Benign hypertrophy prostate</u>				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) <u>610-X</u>			
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?			
22. I hereby certify that I attended the deceased from <u>Jan 8</u> , 19 <u>55</u> , to <u>Jan 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>55</u> , and that death occurred at <u>6:00A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. B. Spalding M.D.</u>				23b. ADDRESS <u>Plattsburg, Mo.</u>		23c. DATE SIGNED <u>Jan 10, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 12, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Stoney Point Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Clinton County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Jan 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> <u>485</u>		25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. W. Taylor</u> <u>Plattsburg, Mo.</u>			

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 *Danell R. Lyon*.....

Licensed Embalmer No. *3640*

P. O. Address *Plattsburg, N.Y.*

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.