

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29818**
4059

FILED SEP 28 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	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 General Hospital No. 1		e. STREET ADDRESS (If rural, give location) 20 2121 Summit	

3. NAME OF DECEASED (Type or Print) a. (First) Archie b. (Middle) _____ c. (Last) Powers			4. DATE OF DEATH (Month) (Day) (Year) 9 9 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8-23-1876	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work considering most of working life, even if retired) Pensioner		10b. KIND OF BUSINESS OR INDUSTRY State	11. BIRTHPLACE (City and State or Foreign Country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Henry Powers	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE None
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. 'Unk.'	17. INFORMANT'S SIGNATURE OR NAME Jackson County Welfare R.C.M.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis		II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)		4500
*This does not mean the mode of dying, such as heart failure, asthenia, 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.)		
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)
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?

22. I hereby certify that I attended the deceased from Sept. 7, 1955, to Sept. 9, 1955, that I last saw the deceased alive on Sept. 9, 1955, and that death occurred at 5:25P m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns (Degree or title)	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 9-12-55
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 9-19-55	24c. NAME OF CEMETERY OR CREMATORY Floral Mt. H.S.	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE RECEIVED BY LOCAL REG. 9-17-55	REGISTRAR'S SIGNATURE Bernie Marshall	25. FUNERAL DIRECTOR'S SIGNATURE B. C. Waid ADDRESS R.C.M.	

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..... *B. E. Weiler*

Licensed Embalmer No. *4070*

P. O. Address *L. O. S.*

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.