

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 23 1955

318

1003

State File No. 38745

10008

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
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)		c. CITY OR TOWN St. Louis		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 Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 4023a Kennerly Ave. 2170				
3. NAME OF DECEASED (Type or Print) a. (First) GUS b. (Middle) POWELL c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Nov 14 1955					
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 23 1902		
9. AGE (In years last birthday) 52		10. MONTHS 10		11. DAYS 21		12. HOURS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Building Trade		11. BIRTHPLACE (City and State or Foreign Country) McNeil Ark		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joe Powell			13b. MOTHER'S MAIDEN NAME Lillian Powell			14. NAME OF HUSBAND OR WIFE Lillian Powell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 492-09-4935		17. INFORMANT'S SIGNATURE OR NAME Lillian Powell 4023a Kennerly Ave				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)								
MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>								
INTERVAL BETWEEN ONSET AND DEATH 24 hrs								
*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.								
DUE TO (b) <u>Hypertensive Cardiac vascular dis. 9 months</u>								
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 4201					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>2/8/55</u> , 1955, to <u>10/13</u> , 1955, that I last saw the deceased alive on <u>10/13</u> , 1955, and that death occurred at <u>2:45 pm.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Dorothy Howard M.D.</u>				23b. ADDRESS 4332 Easton		23c. DATE SIGNED 11/15/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov 18 1955		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Fordyce, Dallas, Co. Ark		
DATE REC'D BY LOCAL REG. NOV 16 1955		REGISTRAR'S SIGNATURE <u>J. Paul Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son 3133 Bell Avenue				

(Licensed Embalmer's Statement on Reverse Side)

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..... *S. J. Watson*

Licensed Embalmer No. *269*

P. O. Address *2769*

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.