

FILED APR 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13049

State File No. _____
REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Clinton</u>		c. CITY OR TOWN <u>Leeton Mo Rt 1</u>	
c. LENGTH OF STAY (If in this place) <u>9 days</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>Wetzel Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>Shawnee Township 0420</u>	
3. NAME OF DECEASED a. (First) <u>CLARK</u> b. (Middle) <u>REYNOLDS</u> c. (Last) <u>POWERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 19, 1879</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>	
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>Farmer</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Henry County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Chas. E Powers</u>		13b. MOTHER'S MAIDEN NAME <u>Carnie Clark</u>	
14. NAME OF HUSBAND OR WIFE <u>Jewena J Foster Powers</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ms. C R Powers</u> ADDRESS <u>Leeton Mo Rt 1</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septicemic pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiovascular renal failure</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 <u>442x</u>	
20. AUTOPSY? YES <input checked="" 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>12-24</u> , <u>1955</u> , to <u>4-22</u> , <u>1956</u> ; that I last saw the deceased alive on <u>4-22</u> , <u>1956</u> , and that death occurred at <u>6:15 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. Powell</u> (Degree or title)		23b. ADDRESS <u>Clinton Mo</u>	
23c. DATE SIGNED <u>4/25/56</u>			
24a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/26/1956</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Shawnee mound</u>		24d. LOCATION (City, town, or county) (State) <u>Henry County Mo.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Melba Bigham</u> ADDRESS <u>Clinton Mo</u>		SCHAUBERG FUNERAL HOME	

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 *F. L. Schabing*

Licensed Embalmer No. *45*

P. O. Address *Clinton*

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.