

FILED MAR 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11429

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>312</u>		PRIMARY REG. DIST. NO. <u>541</u>		Registrar's No. <u>232</u>	
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) --a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON, MISSOURI</u>		c. LENGTH OF STAY (to this place) <u>3 days</u>		c. CITY OR TOWN <u>VINITA PARK</u>		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 <u>ST LOUIS COUNTY HOSP</u>				e. STREET ADDRESS (If rural, give location) <u>2304 NORTH & SOUTH ROAD</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALBERT</u>		b. (Middle) <u>AA</u>		c. (Last) <u>POWERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 17 1957</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>11-4-1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 WRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>BOCNE COUNTY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>CLEM POWERS</u>		13b. MOTHER'S MAIDEN NAME <u>AMELIA FROSCH</u>		14. NAME OF HUSBAND OR WIFE <u>FLOSSIE FERN POWERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>514-09-C469</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>FLOSSIE POWERS 2304 NORTH & SOUTH RD</u>			
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) <u>Myocardial Infarction</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. <u>Bronchietasis</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
						<u>4201</u>	
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>2-19</u> , 19 <u>57</u> , to <u>3-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>10:00 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph C. Gunt MD</u>				23b. ADDRESS <u>601 S. BRENTWOOD BLVD.</u>		23c. DATE SIGNED <u>3/17/57</u>	
24a. BURIAL/CREMATION REMOVAL (Specify)		24b. DATE <u>3-20-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>COLUMBIA, MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>3/19/57</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Donahoe</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ORTMANN F HOME 9222 LACKLAND</u>			

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 *Al. C. Ortman*

Licensed Embalmer No. *3478*

P. O. Address

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.