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FILED AUG 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28460

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 358

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Raytown</u>		c. CITY OR TOWN <u>Raytown</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10503 E 67th</u>		Length of stay in 1b <u>3 yrs</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Power</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1871</u>
9. AGE (In years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	
11. BIRTHPLACE (City and state or country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Albert Brown</u>		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE <u>Albert E. Power</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>16-14-5753</u>		17. INFORMANT Name <u>Irene Weber</u> Address <u>10503 E 67th</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 Min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive disease</u>		<u>10 yrs.</u>	
DUE TO (c) <u>Arterial Sclerosis</u>		<u>20 yrs.</u>	
PART II. 'OTHER SIGNIFICANT' CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 54</u> to <u>Aug 57</u> and last saw her alive on <u>24 July 57</u> Death occurred at <u>2:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the cause stated.		22a. SIGNATURE <u>A. L. Beggs, M.D.</u> (Degree or title)	
22b. ADDRESS <u>RAYTOWN, MO</u>		22c. DATE SIGNED <u>8/12/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>8/13/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>
24. FUNERAL DIRECTOR <u>Kepley-Raytown, Raytown, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-13-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

AUG 24 1957

AUG 20 1957

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 *Walter L. Kasper*
Licensed Embalmer No. *0 4225*
P. O. Address *Indep. 210*

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.