

FILED AUG 26 1957

STANDARD CERTIFICATE OF DEATH

State File No. 29900
Registrar's No. 7411

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 No

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Mary's INFIRMARY
e. STREET ADDRESS (If rural, give location) 3834 Cook Ave

3. NAME OF DECEASED (Type or Print) a. (First) Riley b. (Middle) _____ c. (Last) Powell 4. DATE OF DEATH (Month) (Day) (Year) 8-6-1957

5. SEX Male 6. COLOR (or RACE) Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH 9-18-1905 9. AGE (in years last birthday) 52 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. 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 _____ 11. BIRTHPLACE (City and State or Foreign Country) Miss 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Riley Powell 13b. MOTHER'S MAIDEN NAME Emma Jackson 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y= yes, no, or unknown) (If yes, give war or dates of service) yes in world war I 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Hattie Powell ADDRESS 3834 Cook Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) HEART FAILURE MEDICAL CERTIFICATION DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Stroke INTERVAL BETWEEN ONSET AND DEATH _____
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the medical injury, or complication which caused death.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E9319
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19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 28 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? ell

22. I hereby certify that I attended the deceased from Aug 1, 1957, to Aug 6, 1957 that I last saw the deceased alive on Aug 6, 1957, and that death occurred at 6A m., from the causes and on the date stated above.

23a. SIGNATURE William A. Quinn MD (Degree or title) 23b. ADDRESS 2337 Market 23c. DATE SIGNED Aug 8 57

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 8-12-1957 24c. NAME OF CEMETERY OR CREMATORY Washington Park 24d. LOCATION (City, town, or county) (State) Berkley Mo.

DATE REC'D BY LOCAL REG. AUG 8 57 REGISTRAR'S SIGNATURE Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE Boyd Funerary Home ADDRESS 3704 Finney

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

MS
AUG 23 1960

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 *W. Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *4575 Al*

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.