

FILED DEC 16 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

39187
 STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 453

V. S. 300
 Rev. 1-57 C

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>New Florence</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. Medical Center</u>		Length of stay in 1b <u>8 days</u>	d. STREET ADDRESS (If outside, give location) <u>908</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Powell</u>			4. DATE OF DEATH Month Day Year <u>Dec. 12, 1957</u>		
5. SEX <input checked="" type="checkbox"/> Male	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-02</u>	9. AGE (In years last birthday) <u>55</u> 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) <u>Cattle Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cattle Dealer</u>	11. BIRTHPLACE (City and state or country) <u>New Florence, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>John Price Powell</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Fullington Craig</u>		14. NAME OF HUSBAND OR WIFE	
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>✓</u>	17. INFORMANT Address <u>Hospital Records</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 contusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS (Do not include conditions but not related to the terminal disease condition given in PART I (a).) <u>Renal contusion, fractured ribs, arteriosclerosis, hemothorax</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>automobile accident</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>12/3/57</u> p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Mexico, Mo - Audrain</u>	
21. I attended the deceased from <u>12/12/57</u> to <u>12/12/57</u> and last saw her alive on <u>12/12/57</u> Death occurred at <u>12-25 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ronald Kevers, M.D.</u>			22b. ADDRESS <u>Columbia, Mo.</u>		22c. DATE SIGNED <u>12/12/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>12-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Florence</u>		23d. LOCATION (City, town, or county) (State) <u>New Florence MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Cashier, Montgomery City, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 13, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 our The 12 Day Nec 1957, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Travis J. ...

Licensed Embalmer No. 1487
P. O. Address Montgomery City Md

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.