

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 14 1958

3459
STATE FILE NUMBER
1166

Registration District No. 318 Primary Registration District No. 1008 Registrar's No.

300
1-57

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i> | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) <i>2119 3634 Aldine</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>WALLACE</i> Middle <i>HENRY</i> Last <i>POWELL</i> | | | 4. DATE OF DEATH Month <i>JANUARY</i> Day <i>28</i> Year <i>1958</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 22, 1902</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipper</i> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 9. AGE (In years last birthday) <i>55</i> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ |
| 11a. BIRTHPLACE (City and state or country) <i>Unknown</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13a. FATHER'S NAME <i>Unknown</i> | | 13b. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 14. NAME OF HUSBAND OR WIFE <i>Ora B. Powell</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>Ora B. Powell</i> Address <i>1715 Carver Lane</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE TUBULAR NECROSIS OF KIDNEYS; ETIOLOGY UNKNOWN</i> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>SICKLE CELL TRAIT, CONGENITAL</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>17 DAYS</i> |
| 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 WORK <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 <i>JAN. 17, 1958</i> to <i>JAN. 28, 1958</i> and last saw her alive on <i>JAN. 28, 1958</i> Death occurred at <i>6:20 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Michael M. Karl</i> (Design or title) <i>M. D.</i> | | 22b. ADDRESS <i>BARNES HOSPITAL</i> | |
| 22c. DATE SIGNED <i>1/29/58</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 23b. DATE <i>2/3/58</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i> | |
| 24. GENERAL DIRECTOR <i>E. B. Boone</i> ADDRESS <i>222 N. Grand</i> | | 25. DATE RECD. BY LOCAL REG. <i>JAN 31 '58</i> | |
| | | 26. REGISTRAR'S SIGNATURE <i>Thomas C. Dundon</i> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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 *Clarence Brown*

Licensed Embalmer No. *4755*
P. O. Address *1221 N. Green*

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.