

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-0057886
STATE FILE NUMBER 972

FILED MAR 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4314 E. 16th, St.		d. STREET ADDRESS 4314 E. 16th, St.	
Length of stay in 1b 22 yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Fredrick Powers			4. DATE OF DEATH Month Day Year Feb. 22 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27th, 1892
9. AGE (In years last birthday) 65		10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheffield Steel Mill Switchman		10b. KIND OF BUSINESS OR INDUSTRY Switchman	11. BIRTHPLACE (City and state or country) Linton Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Ola Powers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 495-09-5173	17. INFORMANT Ola Powers
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Arteriosclerosis Generalized DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 4201	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 1954 to 2-22-58 and last saw ^{her} him alive on 2-12-58 Death occurred at 2:55 PM m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) J. M. Haight Sr D	
22b. ADDRESS 3401 E 12th KC Mo		22c. DATE SIGNED 2-22-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/24/58	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem.	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Earp & Sons K. C. Missouri		25. DATE RECD. BY LOCAL REG. 2-22-58	26. REGISTRAR'S SIGNATURE Neva Mitchell

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
J. M. Haight

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 *John B. Epp*
Licensed Embalmer No. *2935*
P. O. Address *K. C. Mo.*

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.