

Health, Welfare, Public Service  
 300  
 1-56  
 Doctor, coronar, etc. must use only standard nomenclature in Part 10. No symptoms will be listed. All diseases in Part 1 must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

58-012656  
 STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 817

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>4000 Country Life Acres</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb <b>2-hrs.</b>	d. STREET ADDRESS # <b>16</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>J.</b> Last <b>Powers Jr.</b>			4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1958</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1906</b>	9. AGE (In years last birthday) <b>51</b> 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, except if retired) <b>Ex. Vice-Pres. McCabe-Powers Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Powers Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Edward J. Powers</b>			14. MOTHER'S MAIDEN NAME <b>Nellie B. Kirk</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>493-10-2483</b>	17. INFORMANT Address <b>Mrs. Anne M. Powers, # 16 Country Life Acres</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sever Shock</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Cerebral concussion, fractured</b>					<b>3 hrs.</b>
DUE TO (c) <b>pelvis, fractured ribs, ruptured bladder</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>and fracture of left hip</b>					
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.) <b>It fell over banister in home (Bannister in)</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY a. m. _____ p. m. <b>6:45</b>	Month, Day, Year <b>3/20/58</b>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		CITY, TOWN, OR LOCATION <b>Spkaut</b>	COUNTY STATE <b>Mo 400</b>
21. I attended the deceased from <b>8:50</b> to <b>3/20/58</b> and last saw her him alive on <b>8:00 P.M.</b>		Death occurred at <b>1:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Comuelher M.D.</b>			22b. ADDRESS <b>4161 Lundeel Blvd</b>		22c. DATE SIGNED <b>3/21/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 24, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>		ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>3-21-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>

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 *Francis William*.....

Licensed Embalmer No. 3

P. O. Address 3840

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.