

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018442  
STATE FILE NUMBER  
2306  
Registrar's No.

FILED MAY 23 1958 Registration District No. 149 Primary Registration District No. 1002

S. 300  
1-57 0

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</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>General Hospital #1</b>		Length of stay in lb <b>70 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>2308 CHARLOTTE STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>EMIL</b> Last <b>Powell</b>			4. DATE OF DEATH Month <b>5</b> - Day <b>3</b> - Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 30 - 1885</b>		9. AGE (In years last birthday) <b>72</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEAMSTER &amp; EMPLOYEE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL KITCHEN</b>		11. BIRTHPLACE (City and state or country) <b>NIAGARA FALLS NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>UNKNOWN POWELL</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE <b>--</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>500-03-9724</b>		17. INFORMANT <b>MRS. ZOE HUBER</b>		Address <b>2306 CHARLOTTE STREET KANSAS CITY MISSOURI</b>	
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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>Carcinoma of Head of Pancreas</b>			INTERVAL BETWEEN ONSET AND DEATH <b>157*</b>				
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 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 _____ 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 <b>4-15-58</b> , to <b>5-3-58</b> and last saw <sup>him</sup> alive on <b>5-3-58</b> Death occurred at <b>12:50</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>General Hospital No. 1</b>			22c. DATE SIGNED <b>5-5-58</b>		
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY 6 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROBAL HILLS CEMETERY</b>		23d. LOCATION (City, town, or county) <b>KANSAS CITY MISSOURI</b>			
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>			ADDRESS <b>1331 BRUSH CREEK KANSAS CITY MO.</b>		25. DATE RECD. BY LOCAL REG. <b>5-6-58</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>		
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(Licensed Embalmer's Statement on Reverse Side)

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

B. I. Burns



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. J. Nelson* .....

Licensed Embalmer No. *4421* .....

P. O. Address *Kansas City* .....

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.