Health,
& Welfare
Public
Service

5. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036088
STATE FILE NUMBER

NOV 3 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1041

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2150 N. Newton — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2150 N. Newton — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: DORA Middle: Last: POWELL

4. DATE OF DEATH Month: Oct. Day: 28 Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 30 Dec. 1869
9. AGE (In years last birthday): 88 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Alie Beckerdite
13b. MOTHER'S MAIDEN NAME: Martha Cavin
14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Herman Powell Address: Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis, acute, left — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) with R. hemiplegia — 2 wks
DUE TO (c) 332X
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Oct 21, 1958 to 10-28-58 and last saw the deceased alive on Oct 21, 1958
Death occurred at 4:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. Wendell Stewart (Degree or title) M.D.
22b. ADDRESS Springfield, Missouri
22c. DATE SIGNED Oct. 29, 1958

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-30-58
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn
23d. LOCATION (City, town, or county) (State): Springfield, Missouri

24. FUNERAL DIRECTOR: J.W. Klingner & Co. ADDRESS: Spgfd. Mo.
25. DATE RECD. BY LOCAL REG.: 10-31-58
26. REGISTRAR'S SIGNATURE: Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

DEC 19 1962

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 ..... Signed Catherine Klingner
Signature of Student Embalmer

Licensed Embalmer No. 3719

P. O. Address .....

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.