

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038117  
STATE FILE NUMBER

1003

8944  
Registration No.

6914  
FILED OCT 20 1958 Registration District No.

318

Primary Registration District No.

S. 300  
1-57

0

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <b>St. Louis, Missouri</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN: <b>Florissant 40510</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION: <b>30 St. Louis Maternity</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>27 100 Castello</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>Powell</b>				4. DATE OF DEATH Month Day Year <b>Aug 31 1958</b>									
5. SEX <b>Male 0</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 29 1958</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Min. <b>1 21</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>						
13a. FATHER'S NAME <b>Thomas "O" Powell</b>				13b. MOTHER'S MAIDEN NAME <b>Virginia Belle Midgett</b>			14. NAME OF HUSBAND OR WIFE <b>None</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>None</b>		17. INFORMANT <b>Thomas &amp; Virginia Powell</b>			Address <b>Florissant, Mo. 100 Castello</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>Intracranial Damage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Intrauterine anoxia</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)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>						
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>762.0</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
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 <b>August 29, 1958</b> to <b>Aug. 31 1958</b> and last saw <sup>her</sup> him alive on <b>August 31, 1958</b> Death occurred at <b>1:55 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>Herman H. Peas, MD</b>					22b. ADDRESS <b>4401 Hampton Ave</b>			22c. DATE SIGNED <b>Sept 10, '58</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-30 58</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>						
24. FUNERAL DIRECTOR <b>Kawland Akew 404 Manchester</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 17 '58</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith MD</b> in 88							

**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 .....

Licensed Embalmer No.....

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.**