

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042117

STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10808

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-57

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</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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. John's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1304 Gimblin St</b>	
Length of stay in lb <b>3 weeks</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Hunt</b> Last <b>Powell</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</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>June 14 1891</b>
9. AGE (In years last birthday) <b>67</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary to President</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Dr. Chas. Hunt Powell</b>	13b. MOTHER'S MAIDEN NAME <b>Annette I. Hereford</b>	14. NAME OF HUSBAND OR WIFE <b>Never married</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>497-18-9773</b>	17. INFORMANT Address <b>Miss Annette Powell, 1304 Gimblin St</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>Arterial Aneurysm</b> DUE TO (b) <b>Synthetic Arterial Transplant</b> DUE TO (c) <b>Surgical Shock</b>			INTERVAL BETWEEN ONSET AND DEATH <b>451X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>while undergoing operation</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter name of institution in PART I or PART II, if applicable) <b>Arterial Aneurysm at St. John's Hospital, on November 7th, 1958.</b>		
20c. TIME OF INJURY Hour <b>11</b> Month, Day, Year <b>7 1958</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, street, office bldg., etc.) <b>Asap</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>
21. I attended the deceased from Death occurred at <b>7:50 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from _____ and last saw her alive on _____	
22a. SIGNATURE <b>Patrick G. Taylor, Curator</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>11/10/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 11 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 ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 10 58</b>	26. REGISTRAR'S SIGNATURE <b>K. Early Smith No. 10808</b>

All diseases in Part I must be causally related. **Arterial Aneurysm & arterial-clavicle**  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 Quoted

**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 *Allen W. Katz* .....

Licensed Embalmer No. *3737* .....  
P. O. Address *St. Louis, 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.