

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046174

STATE FILE NUMBER
12479

DECEASED JAN 12 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If outside, give location) 4560 GRAVOIS	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle W Last POWERS		4. DATE OF DEATH Month DEC Day 22 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 25, 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY CLERK		10b. KIND OF BUSINESS OR INDUSTRY DOLGINS	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME WILLIAM L POWERS		13b. MOTHER'S MAIDEN NAME GERTRUDE NEUMANN	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 497-05-7649	17. INFORMANT Address GERTRUDE POWERS 4560 GRAVOIS
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 Apoplexy			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			334X
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 checked="" type="checkbox"/> NO <input 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 WORK <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 _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John H. Ziegenhein</i>		22b. ADDRESS 1310 Clark	22c. DATE SIGNED 12/26/58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 12/26/1958	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) AFFTON, Mo.
24. FUNERAL DIRECTOR ADDRESS J L ZIEGENHEIN & SONS 7027 GRAVOIS		25. DATE RECD. BY LOCAL REG. DEC 26 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Donald Bonig*

Licensed Embalmer No. *4803*

P. O. Address *H. Bonig M.*

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.