

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001139

STATE FILE NUMBER

FILED FEB 13 1959 Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 14

300
1-57

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Armstrong 04-50 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital		Length of stay in 1b 3 weeks	d. STREET ADDRESS (If outside, give location) ---- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle RUSH Last POWELL			4. DATE OF DEATH Month FEB. Day 5, Year 1959		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1882	9. AGE (In years of birthday) 76	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Boone County, Mo. 6	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Houston Powell		13b. MOTHER'S MAIDEN NAME Elizabeth Burks		14. NAME OF HUSBAND OR WIFE Lorena Mead	
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. None	17. INFORMANT Address Mrs W. R. Powell Fayette, Missouri		

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 Vascular Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 1 month
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 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 Dec 10 1958 to Feb 5 1959 and last saw ^{him} _{her} alive on Feb 5 1959 Death occurred at 10:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <i>Mary K. Shell</i> (Degree or title)		22b. ADDRESS Fayette, Mo		22c. DATE SIGNED 2-9-59	
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE 2/7/1959		23c. NAME OF CEMETERY OR CREMATORY City Cemetery	
				23d. LOCATION (City, town, or county) (State) Fayette, Missouri	

24. FUNERAL DIRECTOR Felipe A. Carr ADDRESS Fayette, Mo.		25. DATE RECD. BY LOCAL REG. 2-9-59		26. REGISTRAR'S SIGNATURE <i>Mary K. Shell</i>	
--	--	---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in their report. No symptoms will be recorded. All diseases in Part I must be causally related.

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ralph A. Carr*

Licensed Embalmer No. *3340*

P. O. Address *Goyette, 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.