

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035988

FILED VS NOV 2 1959 137

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 266

ENDED

1. PLACE OF DEATH a. COUNTY <u>HENRY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WINDSOR</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>105 S. WINDSOR</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>HENRY</u> c. CITY OR TOWN <u>WINDSOR</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>105 S. WINDSOR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE ROBERT POWELL</u>			4. DATE OF DEATH Month Day Year <u>OCT 24, 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MO. STATE FAIR</u>		11. BIRTHPLACE (City and state or country) <u>WARSAW, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>LOUIS W. POWELL</u>		13b. MOTHER'S MAIDEN NAME <u>RACHEL FRYBACK</u>		14. NAME OF HUSBAND OR WIFE <u>ESTHER POWELL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CLAUDE T. POWELL, WINDSOR</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>28 hrs</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year _____		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 <u>10/23/59</u> to <u>10/24/59</u> and last saw <u>him</u> alive on <u>10/23/59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>William Smith M.D.</u>		22b. ADDRESS <u>Windsor, Mo.</u>		22c. DATE SIGNED <u>10/24/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 27, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Knobnoster Cemetery</u>		
FUNERAL DIRECTOR <u>Quane Erving</u>		ADDRESS <u>Sebia Mo</u>		23d. LOCATION (City, town, or county) (State) <u>Knobnoster, Missouri</u>		
25. DATE RECD. BY LOCAL REG. <u>Oct. 29-1959</u>			26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

P. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia

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.