

# FEDERAL BUREAU OF INVESTIGATION

## FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-046925  
 STATE FILE NUMBER  
59-046925

FILED VS JAN 19 1960

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 507

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Francois</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bollinger</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Length of stay in 1b <b>29 das.</b>		c. CITY OR TOWN <b>Lutesville,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 4</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Unknown</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>AVIS</b> Middle <b>E.</b> Last <b>POWERS</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>22,</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-9-1892</b>		<b>9. AGE (last birthday)</b> <b>67</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>13</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HR Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Birdin, Illinois</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					
<b>13a. FATHER'S NAME</b> <b>James Brown</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Martha Smith</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Randall Powers</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>491-26-9280A</b>		<b>17. INFORMANT</b> Address <b>Records, State Hospital No. 4, Farmington, Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion - - - - - instantaneous.</b>  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) <b>Psychosis with cerebral arteriosclerosis.</b>										INTERVAL BETWEEN ONSET AND DEATH  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b>				<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <b>Nov. 23, 1959</b> , to <b>Dec. 22, 1959</b> and last saw her <sup>her</sup> alive on <b>Dec. 22, 1959</b> Death occurred at <b>7:35 P. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> <i>[Signature]</i> (Degree or title)				<b>22b. ADDRESS</b> <b>State Hospital No. 4 Farmington, Missouri</b>				<b>22c. DATE SIGNED</b> <b>12-24-59</b> (State)					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>12/26/59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Boll. Co. Mem.</b>				<b>23d. LOCATION</b> (City, town, or county) <b>Lutesville, Mo.</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Gene Ward Lutesville, Mo. Jan. 13, 1960</b>				<b>25. DATE RECD. BY LOCAL REG.</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

JUL 1 1967

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. P. Laird

Licensed Embalmer No. 4538

P.O. Address Jackson, 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.