

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

STATE FILE NUMBER
2 1905 - 60 - 008740

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri	Length of stay in 1b	c. CITY OR TOWN St. Louis	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Maternity	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2843 Lafayette	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bobby Middle Maxine Last Powers		4. DATE OF DEATH Month February Day 17 Year 1960	
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 Feb. 16 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 1 6 25
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY United States	
13a. FATHER'S NAME Bobby Edward Powers		13b. MOTHER'S MAIDEN NAME Maxine NPN Campbell	
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. None		17. INFORMANT Bobby & Maxine Powers Address 2843 Lafayette	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRANE DISEASE DUE TO (b) _____ DUE TO (c) 773.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hours
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 _____ s.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 Feb. 16, 1960 to Feb. 17, 1960 and last saw her him alive on Feb. 17, 1960 Death occurred at 10:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert A. Quenler MD</i> (Degree or title)		22b. ADDRESS 630 S. Kingshighway Blvd.	22c. DATE SIGNED 2-18-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/18/60	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) Moro, Ark.
24. FUNERAL DIRECTOR E.J. Schnur ADDRESS 3125 Lafayette Ave.		25. DATE RECD. BY LOCAL REG. FEB 18 1960	26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>

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

Thomas R. Jewell

Licensed Embalmer No. 379

P. O. Address 3125 F

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.