

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021394

FILED VS MAY 18 1960

318

1003

4902

STATE FILE NUMBER

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|--|--|---|--|
| 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. | | Length of stay in 1b 40 Yrs. | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5071, WELLS AVENUE | | d. STREET ADDRESS (If outside, give location) 5071, WELLS AVENUE | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|---------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First MYRTLE Middle ALICE Last Keowon Powers POWELL | | | 4. DATE OF DEATH Month 5 - Day 7 - Year 1960 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE COL. | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-2-1919 | 9. AGE (last birthday) 40 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY RAPID EMPLOYMENT AGENCY | | 11. BIRTHPLACE (City and state or country) ST. LOUIS MISSOURI | |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | 13a. FATHER'S NAME Rev. ALBERT B. KEOWON | | 13b. MOTHER'S MAIDEN NAME Hallie HOWARD | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 496-18-9037 | |
| 17. INFORMANT Mrs Hallie Keowon | | Address 5071, WELLS AVE. | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| DUE TO (b) Acute Secondary Anemia | | |
| DUE TO (c) Vaginal Hemorrhage | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) none |
| 20c. TIME OF INJURY Hour a.m. none | Month, Day, Year none | none |
| 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.) none | 20f. CITY, TOWN, OR LOCATION none |
| 20g. COUNTY none | | 20h. STATE none |

21. I attended the deceased from **5-16-60** to **5-7-60** and last saw her **alive** on **5-7-60**
Death occurred at **11:26** **A** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Frayer D. Alexander M.D. | 22b. ADDRESS 5264 CHANNING | 22c. DATE SIGNED 5-9-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 5-13-1960 | 23c. NAME OF CEMETERY OR CREMATORY GREEN WOOD CEMETERY |
| 23d. LOCATION (City, town, or county) ST. LOUIS, MISSOURI | | |

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| 24. FUNERAL DIRECTOR John J. Houston | ADDRESS 2812, THOMAS ST. | 25. DATE RECD. BY LOCAL REG. MAY 10 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION

Handwritten notes:
all papers @ coroner 5/10/60

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 _____

Licensed Embalmer No. 4444

P. O. Address 2812th

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.