

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026426

FILED VS AUG 10 1960

Registration District No. 112 Primary Registration District No. 5428 Registrar's No. 10 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boone</u> | | Length of stay in 1b <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Rosebud</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rosebud route</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>POWERS</u> Last <u>POWERS</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</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>Jan. 1, 1875</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or Country) <u>Redbud, Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Frederich Merz</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>John J. Powers</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 <u>Mrs. Elsie Dudzik, Rosebud, Mo.</u> | | |

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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) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old Fracture of Hip.</u> | 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 |
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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.) |
| 20c. TIME OF INJURY Hour <u>5:15</u> Month, Day, Year <u>3/5/60</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 3/5/60 to 8/4/60 and last saw her/him alive on 7/5/60.
Death occurred at 5:15 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>James J. Shea MD</u> | 22b. ADDRESS <u>Leralda MO</u> | 22c. DATE SIGNED <u>8/5/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 8, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> |
| 23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> | | |

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| 24. FUNERAL DIRECTOR <u>Oltmann Funeral Home, Corral, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Aug 6 - 1960</u> | 26. REGISTRAR'S SIGNATURE <u>John Charles Finley</u> |
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

AUG 17 1960

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

Ernest L. Oldman

Licensed Embalmer No. *4054*

P. O. Address *Union J.*

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.