

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032745

FILED VS SEP 2 1960 318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7248

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Juni Louis sp.</i>				Length of stay in lb <i>1 day</i>		c. CITY OR TOWN <i>University City</i>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Jewish Hosp.</i>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>1129 Purdue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ben OB (AKA BENJAMIN) Powers</i>				4. DATE OF DEATH Month Day Year <i>July 19, 1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>5-1-1895</i>	
9. AGE (last birthday) <i>65</i>		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) <i>Merchant</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Office Fix.</i>			11. BIRTHPLACE (City and state or country) <i>Poland</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>							
13a. FATHER'S NAME <i>Yidel Powers</i>				13b. MOTHER'S MAIDEN NAME <i>Leah (unk)</i>		14. NAME OF HUSBAND OR WIFE <i>Belle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>Unk.</i>		17. INFORMANT <i>Belle Powers</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Surgical Shock. (post operative)</i>						INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <i>Coronary Thrombosis, left</i>							
DUE TO (c) <i>451X</i>							
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 checked="" type="checkbox"/> NO <input 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 _____ and last saw her/him alive on _____ Death occurred at <i>530 R</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Patrick P. Taylor Coroner</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>7.20.60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Reg.</i>		23b. DATE <i>7/21/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>B'nai Amoona</i>		23d. LOCATION (City, town, or county) (State) <i>University City, Mo.</i>	
24. FUNERAL DIRECTOR <i>Berger Memorial 4715 McPherson</i>				25. DATE RECD. BY LOCAL REG. <i>JUL 20 1960</i>		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

629  
887  
HP7

**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 *Quir G. Gudwig*  
Licensed Embalmer No. 4229

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.