MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

60-038514
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5261

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 20 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 514½ Main st. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle MASTERSON Last POWELL

4. DATE OF DEATH: Month 10 Day 16 Year 60

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12-10-94
9. AGE (last birthday): 65
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): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Home Decorating
11. BIRTHPLACE (City and state or country): Livingston Co., Kentucky
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Samuel Gibson Powell
13b. MOTHER'S MAIDEN NAME: Blanche Judd
14. NAME OF HUSBAND OR WIFE: Sarah Alice Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr. William M. Powell Jr. Address: R R #3 Indep., Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchial pneumonia, bilateral
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tuberculosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9-20-60 to 10-16-60 and last saw ~~him~~ alive on 10-16-60
Death occurred at 9:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H L Dwyer (Degree or title) M.D.
22b. ADDRESS 2400 Cherry St. - K.C., Mo.
22c. DATE SIGNED 10-18-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-20-60
23c. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Kansas

24. FUNERAL DIRECTOR ADDRESS: WEILERT FUNERAL HOME(S) K.C., MO.
25. DATE RECD. BY LOCAL REG.: 10-19-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF H. L. Dwyer MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. E. Weibert

Licensed Embalmer No. 402

P. O. Address K. C. 8, M

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