

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048806

FILED VS JAN 23 1961

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6558 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>12 Years</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4152 Holly Street</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4152 Holly Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Cecelia</b> Last <b>Powers</b>	4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/08</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Paul Lucas</b>	13b. MOTHER'S MAIDEN NAME <b>Rose Douglass</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph O. Powers</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-01-6719</b>	17. INFORMANT <b>Jos. O. Powers, 4152 Holly, K.C. Mo.</b>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Coronary occlusion</b>	<b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	<b>1 yr.</b>
	DUE TO (c) <b>Miscellaneous</b>	<b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>		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 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.)
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20c. TIME OF INJURY Hour <b>5:00 AM</b> 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 <b>Kansas City</b>	COUNTY <b>Missouri</b>	STATE
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21. I attended the deceased from <b>Dec 27, 1960</b> to <b>12/27/60</b> and last saw her <b>alive</b> on <b>December 27, 1960</b> Death occurred at <b>5:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>M. B. Casebolt</b> (Degree or title)	22b. ADDRESS <b>4000 Baltimore, K. C. Mo.</b>	22c. DATE SIGNED <b>12/28/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/29/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Jos. A. Butler's Sons, K. C. Kansas</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-28-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L-Dwyer</b>
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BY AFFIDAVIT OF MEDICAL CERTIFICATION M. B. Casebolt DOCUMENT

**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 \_\_\_\_\_  
*Paul Pease*

Licensed Embalmer No. 34267  
P. O. Address KC Kansas

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.