

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002206

FILED VS JAN 16 1961 200

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 7

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

INSTEAD OF

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon Hudson</u>			Length of stay in 1b <u>17 days</u>		c. CITY OR TOWN <u>New Cambria</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lake View Rest Home</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie McKinley Powell</u>				4. DATE OF DEATH Month Day Year <u>January 1, 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/02</u>	9. AGE (last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>24</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>New Cambria, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Robert Powell</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jane Roberts</u>			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) <u>No.</u>			16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Clarence G. Powell, Kansas City, Mo.</u>		
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>Hydrostatic Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>General Paralysis (Luetia)</u>							<u>5 years</u>
DUE TO (c) _____							
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 checked="" 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.) -----					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____							
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 <u>Dec 20, 1960</u> to <u>Jan 1, 1961</u> and last saw him alive on <u>Jan 1, 1961</u> Death occurred at <u>10:30 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R.L. Moody M.D.</u>				22b. ADDRESS <u>Macon Missouri</u>			22c. DATE SIGNED <u>1/3/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cambria</u>		23d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>H.J. Gilleland, New Cambria, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Jan. 3, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ruth W. Neely</u>			

JAN 24 1961

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 H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, Pa.

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.