

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005810

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 111

AMENDED

FILED MAR 13 1962

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		Length of stay in 1b <u>12 Hours</u>	c. CITY OR TOWN <u>CHAFFEE</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>CAPE OSTEPHTIC</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>127 BLACK</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>BABY GIRL</u> Middle <u>POWERS</u> Last <u>POWERS</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>25</u> Year <u>1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 24 1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>22</u> Days <u>2</u> Hours <u>22</u> Min.	IF UNDER 24 HR Hours <u>22</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>CHAFFEE MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JESS POWERS</u>		13b. MOTHER'S MAIDEN NAME <u>DONNA JEAN STOUT</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. Jess Power</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mr. Jess Power</u> Address <u>CHAFFEE MO</u>		

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) <u>Respiratory System Membrane</u>		<u>15 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Prematurity</u>	<u>15 hr.</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 type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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 <u>5:55</u> a.m. p.m.	Month, Day, Year <u>2/24/62</u>	
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 2/24/62 to 2/25/62 and last saw ^{her} _{him} alive on 2/25/62
Death occurred at 5:55 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Kenneth D. Bess D.O.</u> (Degree or title)	22b. ADDRESS <u>Chaffee, MO.</u>	22c. DATE SIGNED <u>2/26/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-25-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>CHAFFEE MO</u>
24. FUNERAL DIRECTOR <u>W. Stubbins - CHAFFEE MO</u>	25. DATE RECD. BY LOCAL REG. <u>3-5-1962</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 Eugene L. Stubbins

Licensed Embalmer No. 5012

P. O. Address Chaffee, Ma

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.