

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008593

STATE FILE NUMBER

318

1003

2082

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2082

DO NOT WRITE ON THIS STUB

FILED MAR 7 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in Tb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
		St. Louis, Mo.				Missouri.		New Madrid		New Madrid		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		St. Louis City Hospital		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		710 Scott, St.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH				
				Thomas		Chester		Powell		February		19, 1962		
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		
Male		White				4/27/1929		32		Months Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY				
Service Station Mgr.				Oil Co.				Tenn.		U.S.A.				
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE						
James Powell				Bertha Glass				Anna Lee Powell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
No.				Nil.		Anna Lee Powell		710 Scott, St.						
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)														
DUE TO (b) Massive Hemorrhage (Cerebral)														
DUE TO (c) into the left Ventricle of the brain.														
331X														
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 _____ to _____ and last saw her/him alive on _____														
Death occurred at _____ ^{3:55 P.} _____ m on the date stated above, and to the best of my knowledge, from the causes stated.														
22a. SIGNATURE						(Degree or title)			22b. ADDRESS			22c. DATE SIGNED		
Paul J. Simon						Deputy Coroner			1300 Clark			2/20/62		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)						
Removal		2-19-62		Mounds Cemetery				New Madrid, Mo.						
24. FUNERAL DIRECTOR						ADDRESS			25. DATE RECD. BY LOCAL REG.			REGISTRAR'S SIGNATURE		
Albert H. Hoppe Inc.,						4700 Washington, Blvd.			FEB 20 1962			Paul Smith, M.D.		

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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MAR 12 1962

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 John J. Harris

Licensed Embalmer No. 4108

P. O. Address St Louis, Mo

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.