

Dept. Health,  
Educ., & Welfare  
U. S. Public  
Health Service

FILED APR 17 1962

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-62-014708  
STATE FILE NUMBER

Registration District No. 89 Primary Registration District No. 5330 Registrar's No. 9

DO NOT  
ON THIS

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The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CRAWFORD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OSAGE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>HUZZAH 02901</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>90 4MI SE. HUZZAH</u>		Length of stay in 1b <u>60YRS</u>	d. STREET ADDRESS (If outside, give location) <u>4MI SE. HUZZAH</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE JOSEPHINE POWER</u>			4. DATE OF DEATH Month Day Year <u>APR. 13 1962</u>
5. SEX <u>1 FEMALE</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>12-15-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>ST. FRANCIS Co. MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>FLOYD POWER</u>		13b. MOTHER'S MAIDEN NAME <u>MAGGIE SHIFLER</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. <u>NONE</u>		17. INFORMANT <u>HAROLD POWER</u> Address <u>HUZZAH, 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>Senile debility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>794X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			
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>7/19/56</u> to <u>4/12/62</u> and last saw her alive on <u>4/12/62</u> Death occurred at <u>8:00 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Amelia P. [Signature]</u> (Degree or title) <u>DO 2</u>		22b. ADDRESS <u>Steelville</u>	
22c. DATE SIGNED <u>4/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-15-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CENTER POST</u>		23d. LOCATION (City, town, or county) (State) <u>CRAWFORD Co. MO</u>	
24. FUNERAL DIRECTOR <u>JONAS FUNERAL HOME, STEELVILLE, MO</u>		25. DATE RECD. BY LOCAL REG. <u>4/14/62</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs Hazel Lichner</u>			

USE BLACK INK

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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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Steelville,

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.