

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039429

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 217

**FILED OCT 24 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>MO</u> b. COUNTY <u>CARROLL</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Bogard</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>VAN HORN TWP</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond Reath Powell</u>			4. DATE OF DEATH Month Day Year <u>Oct 16 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1888</u> 9. AGE (last birthday) <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baseball Player</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baseball</u>	11. BIRTHPLACE (City and state or country) <u>Arkansas</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Henry Powell</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Brock</u>	14. NAME OF HUSBAND OR WIFE <u>Ernestine Powell</u>
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. <u>[REDACTED]</u>	17. INFORMANT Address <u>Mrs. Ray Powell Bogard, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>8-6-62</u> 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 <u>8-6-62</u> to <u>10-16-62</u> and last saw <sup>him</sup> alive on <u>10-16-62</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W.M. Powell, M.D.</u>		22b. ADDRESS <u>Chillicothe MO</u>	22c. DATE SIGNED <u>10-18-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Oct. 18-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Bogard MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>TICKEYSON &amp; RICE Bogard Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 18, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Amalee Taylor</u>

NOV 1 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 Samuel M. Rice

Licensed Embalmer No. 5087

P. O. Address Boyard, 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.