

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044737

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10725** STATE FILE NUMBER

FILED NOV 9 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		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Missouri COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		St. Louis				c. CITY OR TOWN		St. Louis				Yes <input type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				4642 Elmbank		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		Month		Day		Year								
			Beulah				Powell		11		5		62										
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											
Fem.		Negro				15 Aug 1916		62		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											
Housewife				Louisiana				U. S. S.															
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Dave Mc Gee				Annie Montgomery				Thomas G Powell															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, No war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No								Mr Thomas G Powell 4642 Elmbank															
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)												Undet.											
Cerebral Thrombosis																							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																							
DUE TO (b)																							
Arteriosclerosis, Generalized																							
DUE TO (c)																							
332X																							
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.															
Diverticuli of Colon								<input type="checkbox"/> Yes <input checked="" 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		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>10-18-62</u> to <u>11-5-62</u> and last saw him alive on <u>11-5-62</u>																							
Death occurred at <u>4:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE						22b. ADDRESS						22c. DATE SIGNED											
<i>Thos G Powell M.D.</i>						2601 N. Whittier						11-7-62											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)											
Removal				11/9/62				Washington Park				St. Louis County Missouri											
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
Herman J. Smith						4247/w Labadie						NOV 8 1962						<i>Loard Smith. M.D.</i>					

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 Arthur L. Halliday

Licensed Embalmer No. 4221

P. O. Address 3100 Eastoy Ave

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.