

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 284 Primary Registration District No. 108

1. PLACE OF DEATH:
 (a) County St. Louis 2
 (b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
237 E. Kirkham
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) June 10 1886

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Webster Groves Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 237 E. Kirkham
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Maria Powell 400
3. (b) If veteran, name war ✓ **3. (c) Social Security** No. _____
4. Sex Female **5. Color or race** negro
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive ✓ years 1850
7. Birth date of deceased (Month) ? (Day) ? (Year) 1850

8. AGE: Years about 89 Months _____ Days _____ If less than one day hr. _____ min. _____
9. Birthplace Lexington Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Laundress

11. Industry or business ✓
MOTHER FATHER
12. Name Teed
13. Birthplace Virginia 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Ruth Oliver
(b) Address 570 Emma ave
17. (a) _____ **(b) Date thereof** 7-23-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson
18. (a) Signature of funeral director J. C. Lewis
(b) Address 2740 Webster Groves
19. (a) Aug 22 1939 **(b)** D. R. [Signature]
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 20th
 year 1939 hour 5 minute 35 P. M.
21. I hereby certify that I attended the deceased from June 10-27
June 10 1938 to July 20 1939;
 that I last saw her alive on 7/20/1939, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bath belt twisted round neck
fast to middle of neck
Due to superficial laceration of neck
Due to _____
Other conditions none 98
(Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy no
PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) none
(b) Date of occurrence none
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
none
(Specify type of place)
While at work: none **(e) Means of injury** _____
23. Signature [Signature] (M. D. or other)
Address 570 Emma ave **Date signed** _____

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 _____

✓ _____, Registered Apprentice No. _____
working under my personal supervision.

Signed James Lewis
Licensed Embalmer No. 2027
P. O. Address 22 Euclid - Webster

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 this body is not embalmed, above space should be left blank.