

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3311633
Registrar's No. 8226

REG. DISTRICT NO. 1008 791

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County g
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3724a St. Louis Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 3724a St. Louis Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

William F. Powers 100

3. (b) If veteran, name war no

3. (c) Social Security No. unk

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Theresa

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 4 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 10 20 _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Bonded Weigher

11. Industry or business Merchants Exchange

MOTHER, FATHER {
12. Name Unknown Powers 5
13. Birthplace " Ireland 5
(City, town, or county) (State or foreign country)
14. Maiden name " Duggan
15. Birthplace " Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Lillie Walker
(b) Address 3724a St. Louis Ave.

17. (a) Burial (b) Date thereof 9 - 27 - 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director C. H. ...
(b) Address 1416 N. ...

19. (a) SEP 25 1939 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24
year 1939 hour 4:00 minute _____ A.M.
21. I hereby certify that I attended the deceased from August 27,
1939, to Sept 24, 1939;
that I last saw him alive on Sept 23, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Coma
Duration 4 Days

Due to Cardio-renal insufficiency and Scurvy

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Joseph F. ... (M. D. or other) M.D.
Address 502 N. Grand Blvd Date signed 9/25/39

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.....

Frank L. Leimon....., Registered Apprentice No. *174*
working under my personal supervision.

Signed *Clement McNeary*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.