

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
715 Washington Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 yrs
(Specify whether years, months or days)

FILED FEB 17 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
(c) City or town WEBSTER & POWERS NR
(If outside city or town limits, write "RURAL")
(d) Street No. 224 KURRISH PL.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 23 day JAN
year 1940 hour 12⁵⁰ minute 9 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____
Myringitis

Due to _____
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?

While at work _____ (Specify type of place)
(e) Means of injury _____

23. Signature Joseph M. [unclear] (M. D. or other) _____
Address Deputy [unclear] Date signed _____

3. (a) PRINT FULL NAME LOUIS SCOTT POWELL

8. (b) If veteran, name war 726 8. (c) Social Security No. 494-05-6549

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife KATHERINE POWELL 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased AUG 22 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 5 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace GRANBERRY TEXAS
(City, town, or county) (State or foreign country)

10. Usual occupation TRAFFIC ENGINEER

11. Industry or business BELL TELEPHONE

12. Name SID POWELL

13. Birthplace TEXAS
(City, town, or county) (State or foreign country)

14. Maiden name STELLA DONALDSON

15. Birthplace TEXAS
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs L Scott Powell

(b) Address 224 Kurrish Place Webster

17. (a) Jan 25 (b) Date thereof Jan 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GRANBURY TEXAS

18. (a) Signature of funeral director Parker and Co.

(b) Address Webster Groves 8111

19. (a) JAN 25 1940 (b) _____
(Date received local registrar) (Date received at state office)

WHILE FILING - USE WRAPPING BLACK INK - MAKE A PERMANENT RECORD

1 X 1931

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.

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 *E. L. Aldrich*

Licensed Embalmer No. 1332

P. O. Address Webster Prairie

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.