. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42844

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10722

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 20yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2910 Thomas St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Olivia Powell
3. (b) If veteran, name war
3. (c) Social Security No. 489-07-3054
4. Sex female
5. Color or race col
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 27th (Day) 1905 (Year)
8. AGE: Years 41 Months 9 Days 13 If less than one day hr. min.
9. Birthplace Vaughn (City, town, or county) Miss. (State or foreign country)
10. Usual occupation Maid
11. Industry or business
FATHER 12. Name George Powell
13. Birthplace Unk (City, town, or county) Miss (State or foreign country)
MOTHER 14. Maiden name Leora Washington
15. Birthplace Vaughn (City, town, or county) Miss (State or foreign country)
16. (a) Informant Gertie White
(b) Address 2830 Thomas Street
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-16-46 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson
18. (a) Signature of funeral director J. H. Randle & Son
(b) Address 3133 Bell Avenue
19. (a) DEC 15 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10 year 1946 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from 12-7, 19 46 to 12-10, 19 46 that I last saw her alive on Dec. 10, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	Undet.
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. B. Williams (M. D. or other)
Address 2601 N Whittier Date signed 12/10/46

(Licensed Embalmer's Statement on Reverse Side)

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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

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, fact should be so stated above.