

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37563

State File No.

FILED DEC 15 1951

5084

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 3 1/2 years		d. STREET ADDRESS (If rural, give location) 722 Ward Pkwy., Lowell Apts.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 722 Ward Pkwy., James Russell Lowell Apts.			

3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) POWERS c. (Last) SEILER			4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1951		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 22, 1886	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William G. Powers	13b. MOTHER'S MAIDEN NAME Wolfenden	14. NAME OF HUSBAND OR WIFE Sam S. Seiler
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Sam A. Seiler, 722 Ward Pkwy., KC Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis		DUE TO (b) Carcinoma of the Breast		5 years
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		5 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				170*

19a. DATE OF OPERATION 1946	19b. MAJOR FINDINGS OF OPERATION As above	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June, 1950, to Nov. 26, 1951; that I last saw the deceased alive on Nov 26, 1951, and that death occurred at 11 A m., from the causes and on the date stated above.

23a. SIGNATURE Arnold V. Arms (Degree or title) MD	23b. ADDRESS 4635 Wyandotte St. City Mo	23c. DATE SIGNED 11/26/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/28/51	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 11-27-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE, Kansas City, Missouri
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Arnold V. Aron
411 Nichols St.
Jc 2305

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
Student Embalmer

Signed

Eugene [Signature]
Licensed Embalmer No. 6330
P. O. Address *[Signature]*

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.