

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14674

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3377**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY 2219	
c. LENGTH OF STAY (in this place) 30 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2320 Cole	

3. NAME OF DECEASED (Type or Print) Haywood Powell			4. DATE OF DEATH (Month) (Day) (Year) March 31 1952		
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep.	
8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 76?		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Unknown	
12. CITIZEN OF WHAT COUNTRY? Yes		13a. FATHER'S NAME White Powell		13b. MOTHER'S MAIDEN NAME Louise Powell	
14. NAME OF HUSBAND OR WIFE Not known		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes		18. ADDRESS 2601 N Whittier St		19. INTERVAL BETWEEN ONSET AND DEATH Undet.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prob. Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH Undet.	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) Cerebral Vascular Disease		Undet.	
		DUE TO (c) None			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None			

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 334X	

22. I hereby certify that I attended the deceased from **11-24 1950**, to **3-31 1952**, that I last saw the deceased alive on **3-31 1952**, and that death occurred at **8 1/2** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Herbert E. Krumholz, D.O.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-3-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) 11-4-30 J2		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24e. NAME OF CEMETERY OR CREMATORY		24f. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REG. APR 10 1952		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland H. 104 Manchester	
				ADDRESS	

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

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.....

Licensed Embalmer No. _____

P. O. Address _____

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.