

FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1173**

BIRTH NO. **5432-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		STREET ADDRESS (If rural, give location) 4107 North Broadway	
3. NAME OF DECEASED a. (First) ELTON b. (Middle) LEROY c. (Last) POWERS		4. DATE OF DEATH (Month) (Day) (Year) 1 14 55	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 1-14-55
9. AGE (In years last birthday) 13 IF UNDER 1 YEAR Months 5 IF UNDER 24 HRS. 5		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Alveord Powers		13b. MOTHER'S MAIDEN NAME Marie Hirschfield	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death. Mother had placenta praevia	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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)	
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? 7615		22. I hereby certify that I attended the deceased from 1-14 , 19 55 , to 1-14 , 19 55 , that I last saw the deceased alive on 1-14 , 19 44 , and that death occurred at 3:10 P.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Mary A. Davis, M.D. 0		23b. ADDRESS 1515 Lafayette Ave.	
23c. DATE SIGNED 1-20-55		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 2-27-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS	
DATE REC'D BY LOCAL REG. FEB 8 1955		REGISTRAR'S SIGNATURE J. Carl Smith	

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.....
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.