

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33003

State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>4 Mo.</u>		c. CITY OR TOWN <u>Kirksville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>402 South Elson</u>				STREET ADDRESS (If rural, give location) <u>402 S. Elson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Myra</u>		b. (Middle) <u>B.</u>		c. (Last) <u>Powell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 20 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED OR YET MARRIED? <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 21 1867</u>		9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leather Goods</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>South Wayne, Wisc.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Daniel J. Rockwell</u>		13b. MOTHER'S MAIDEN NAME <u>Lavina</u>		14. NAME OF HUSBAND OR WIFE <u>Frank A. Powell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Clarence D. Powell 402 S. Elson Kirksville, Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Arterio Sclerosis for years</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>331x</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1926</u> , to <u>Oct 20, 1956</u> , that I last saw the deceased alive on <u>Oct 19, 1956</u> , and that death occurred at <u>7 PM</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Uda Belle Harrison</u>				23b. ADDRESS <u>W. Kirksville Mo.</u>		23c. DATE SIGNED <u>Oct 22 56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 24 1956</u>	24c. NAME OF CEMETERY OR CREMATORIA <u>Hazelwood</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Greene, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-21-56</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Novak, Foster Kirksville, Mo.</u>			

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 *David E. Foster*

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo

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.