

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43695

FILED DEC 27 1956

318

1003

STATE FILE NUMBER 11267

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>ST. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home</i>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <i>312 1119 Bayard</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dr. Charles Monroe Powell</i>				4. DATE OF DEATH Month Day Year <i>Dec. 7 1956</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 7 1892</i>		9. AGE (In years last birthday) <i>84</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Doctor</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Medicine</i>			11. BIRTHPLACE (City and state or country) <i>Hissop Ala.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Powell</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>unk known</i>			16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT Address <i>Sadie Powell 1119 Bayard</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Valvular Chr Val. Heart Disease</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <i>9/1/56</i> to <i>12/7/56</i> and last saw her alive on <i>12/6/56</i> . Death occurred at <i>12/7/56 9:30A</i> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>W.C. Bridgely M.D.</i>				22b. ADDRESS <i>941 N. Durket</i>				22c. DATE SIGNED <i>12-8-56</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>12-10-1956</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Price Benevolent order of Friends 2829 Washington</i>				25. DATE RECD. BY LOCAL REG. <i>DEC 10 1956</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Call Mr.

Doctor, coroner, etc. must use only standard non-removable ink. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

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 *Wallace R. Williams*

Licensed Embalmer No. *49*
4554 *Lexington*
P. O. Address
St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.