Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-032926
STATE FILE NUMBER

FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4015

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Trinity Luth. — Length of stay in 1b: 10 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas b. COUNTY: Johnson
c. CITY OR TOWN: Kansas City 6150 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4933 Buena Vista Dr. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Alice Middle: Carrie Last: Powell

4. DATE OF DEATH: Month: 8 Day: 19 Year: 1958

5. SEX: Fe.
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 2-23-1872
9. AGE (In years last birthday): 86 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Breckridge, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Wells
13b. MOTHER'S MAIDEN NAME: Sara Evaline Edmonds
14. NAME OF HUSBAND OR WIFE: Wm. Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Sidney R. Powell, Address: 5235 Catalina, K.C.K

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis, Coronary — 2-3 yrs.
DUE TO (c): Arteriosclerosis Generalized.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Gangrene of Fingers & feet 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Aug 14, 1958, to Aug 19, 1958 and last saw her alive on Aug 19, 1958
Death occurred at 11 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Otto W. Theel M.D. (Degree or title)
22b. ADDRESS: 4301 Main St.
22c. DATE SIGNED: 8/20/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-20-1958
23c. NAME OF CEMETERY OR CREMATORY: Eustis Cemetery
23d. LOCATION (City, town, or county) (State): Eustis, Neb.

24. FUNERAL DIRECTOR ADDRESS: Gates Funeral Home, K.C. Kans.
25. DATE RECD. BY LOCAL REG.: 8-20-58
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Otto W. Theel

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 Murray Wilson

Licensed Embalmer No. 4989

P. O. Address Shawnee

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.