

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023791

STATE FILE NUMBER

AMENDED

FILED JUN 27 1961 <sup>360</sup> Primary Registration District No. 6225 Registrar's No. 89

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Vernon</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Ozark</b> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Washington Township</b>  |  | Length of stay in 1b<br><b>3 years</b>  |  | c. CITY OR TOWN <b>Gainsville</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>State Hospital No. 3</b>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>---</b>   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Leo</b> Middle <b>E.</b> Last <b>Powers</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>15</b> Year <b>61</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-12-1888</b>  | 9. AGE (last birthday)<br><b>73</b>  | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HR<br>Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Omaha, Nebraska</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>Henry Powers</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Eubank</b>                                 |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Lena Powers</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>?</b>   |  |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Hospital records</b><br>Address <b>1127 S. Clay, Nevada, Mo.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b>   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Arterio-sclerosis.</b>  |  |   |  |   |  |  |  |
| DUE TO (c) <b>Chronic brain syndrome</b>   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 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.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.  |  | Month, Day, Year  |  |   |  |  |  |
| 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 <b>11-1-59</b> , to <b>6-15-61</b> and last saw her/him alive on _____<br>Death occurred at <b>6:00 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>F.S. Martis M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>St. Joseph # 2</b>   |  | 22c. DATE SIGNED<br><b>6-15-61</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county) (State)  |  |  |
| <b>Burial</b>  |  | <b>6/19/61</b>  | <b>Mt. Calvary Cemetery</b>  |   | <b>Nevada, Missouri</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Temp Funeral Home, Nevada, Missouri</b>   |  |   | ADDRESS  | 25. DATE RECD. BY LOCAL REG.<br><b>6-21-61</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Anna E. Jerry</b>                                    |  |  |

(Licensed Embalmer's Statement on Reverse Side)

**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 L. August Ferry

Licensed Embalmer No. 4960

P. O. Address Nevada, 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.