

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001795

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 160

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 28 1963

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. Robinson

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 65 Yrs	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4600 Nichols Parkway	
3. NAME OF DECEASED (Type or print) First Illga Middle H Last Powell		4. DATE OF DEATH Month Jan. Day 8 Year 1963			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1875	9. AGE (last birthday) 87 Yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Abraham H. Herbel		13b. MOTHER'S MAIDEN NAME Anna Michel		14. NAME OF HUSBAND OR WIFE Elmer N. Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Dorothy D. Powell 4600 Nichols Parkway		
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY...)					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage.					24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential Hypertension					3 yrs.
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. Month, Day, Year 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 <u>1960</u> to <u>1-8-63</u> and last saw her/him alive on <u>1-8-63</u> . Death occurred at <u>11 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>W. Robinson MD</i>			22b. ADDRESS <i>K.C. Mo.</i>		22c. DATE SIGNED <i>1-10-63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-10-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 1-10-63	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>		

R. A. W. Robinson
4320 W. 1st
Je 1-0552

SEAL

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 Richard L. Powers

Licensed Embalmer No. 5190

P. O. Address K.C. 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.