

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-030849**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2110

STATE FILE NUMBER

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

|                                                                                                                                                                                                                                                   |                                                                                                                        |                                                                                                                                                                     |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------|
| <p><b>FILED JUL 25 1963</b></p> <p>1. PLACE OF DEATH<br/>a. COUNTY <u>St. Louis</u></p>                                                                                                                                                           |                                                                                                                        | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br/>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u></p>                     |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
| <p>b. CITY (If outside corporate limits, give TOWNSHIP only)<br/>OR TOWN <u>Koch</u></p>                                                                                                                                                          |                                                                                                                        | <p>Length of stay in 1b<br/><u>190 days</u></p>                                                                                                                     | <p>c. CITY OR TOWN <u>St. Louis</u></p>                                             | <p>Inside Limits<br/>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>                                                                                 |                                                   |                                      |
| <p>c. FULL NAME OF (If NOT in hospital, give location)<br/>HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u></p>                                                                                                                                |                                                                                                                        | <p>Inside Limits<br/>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>                                                                        | <p>d. STREET ADDRESS (If outside, give location)<br/><u>3644 Cote Brilliant</u></p> | <p>Reside on Farm<br/>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>                                                                                |                                                   |                                      |
| <p>3. NAME OF DECEASED (Type or print)<br/><u>Revell</u> <sup>First</sup> <u>Powell</u> <sup>Middle</sup> <u>Lyn</u> <sup>Last</sup></p>                                                                                                          |                                                                                                                        |                                                                                                                                                                     | <p>4. DATE OF DEATH<br/>Month <u>6</u> Day <u>28</u> Year <u>63</u></p>             |                                                                                                                                                                              |                                                   |                                      |
| <p>5. SEX <u>M</u></p>                                                                                                                                                                                                                            | <p>6. COLOR OR RACE <u>C</u></p>                                                                                       | <p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br/>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>2-8-08</u></p>                                               | <p>9. AGE (last birthday) <u>63</u></p>                                                                                                                                      | <p>IF UNDER 1 YEAR<br/>Months Days Hours Min.</p> | <p>IF UNDER 24 HR<br/>Hours Min.</p> |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>                                                                                                                                                |                                                                                                                        | <p>10b. KIND OF BUSINESS OR INDUSTRY<br/>---</p>                                                                                                                    | <p>11. BIRTHPLACE (City and state or country)<br/><u>Tenn.</u></p>                  |                                                                                                                                                                              | <p>12. CITIZEN OF WHAT COUNTRY<br/><u>USA</u></p> |                                      |
| <p>13a. FATHER'S NAME<br/><u>Clay Powell</u></p>                                                                                                                                                                                                  |                                                                                                                        | <p>13b. MOTHER'S MAIDEN NAME<br/><u>Minnie Newsome</u></p>                                                                                                          |                                                                                     | <p>14. NAME OF HUSBAND OR WIFE<br/>---</p>                                                                                                                                   |                                                   |                                      |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</p>                                                                                                                                   |                                                                                                                        | <p>16. SOCIAL SECURITY NO.</p>                                                                                                                                      | <p>17. INFORMANT Address<br/><u>Robert Koch Hospital, Koch, Mo.</u></p>             |                                                                                                                                                                              |                                                   |                                      |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br/>PART I. DEATH WAS CAUSED BY:</p>                                                                                                                                  |                                                                                                                        |                                                                                                                                                                     |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
| <p>IMMEDIATE CAUSE (a) <u>Bilateral Lung Abscess</u></p>                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                     |                                                                                     | <p>INTERVAL BETWEEN ONSET AND DEATH<br/><u>6 mos.</u></p>                                                                                                                    |                                                   |                                      |
| <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</p>                                                                                                                                                 |                                                                                                                        |                                                                                                                                                                     |                                                                                     | <p><u>Bilateral Bronchiectasis</u></p>                                                                                                                                       |                                                   |                                      |
| <p>DUE TO (b) <u>526X</u></p>                                                                                                                                                                                                                     |                                                                                                                        |                                                                                                                                                                     |                                                                                     | <p><u>?</u></p>                                                                                                                                                              |                                                   |                                      |
| <p>DUE TO (c)</p>                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                                     |                                                                                     | <p><u>526X</u></p>                                                                                                                                                           |                                                   |                                      |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>                                                                                                          |                                                                                                                        |                                                                                                                                                                     |                                                                                     | <p>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</p> |                                                   |                                      |
| <p>19. WAS AUTOPSY PERFORMED?<br/>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>                                                                                                                                         | <p>20a. ACCIDENT, SUICIDE, HOMICIDE<br/><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>                                                                 |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
| <p>20c. TIME OF INJURY<br/>Hour a.m. p.m.<br/>Month, Day, Year</p>                                                                                                                                                                                |                                                                                                                        |                                                                                                                                                                     |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
| <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>                                                                                                                                     | <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                        | <p>20f. CITY, TOWN, OR LOCATION</p>                                                                                                                                 | <p>COUNTY</p>                                                                       | <p>STATE</p>                                                                                                                                                                 |                                                   |                                      |
| <p>21. I attended the deceased from <u>12-20-62</u> to <u>6-28-63</u> and last saw her/him alive on <u>6-28-63</u>.<br/>Death occurred at <u>7:08 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p> |                                                                                                                        |                                                                                                                                                                     |                                                                                     |                                                                                                                                                                              |                                                   |                                      |
| <p>22a. SIGNATURE (Degree or title)<br/><u>Arthur R. Brown, M.D.</u></p>                                                                                                                                                                          |                                                                                                                        | <p>22b. ADDRESS<br/><u>Robert Koch Hospital</u></p>                                                                                                                 |                                                                                     | <p>22c. DATE SIGNED<br/><u>6-29-63</u></p>                                                                                                                                   |                                                   |                                      |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p>                                                                                                                                                                                                  | <p>23b. DATE<br/><u>7-3-63</u></p>                                                                                     | <p>23c. NAME OF CEMETERY OR CREMATORY<br/><u>Oakdale Cemetery</u></p>                                                                                               | <p>23d. LOCATION (City, town, or county)<br/><u>Lemay, Missouri</u></p>             | <p>(State)</p>                                                                                                                                                               |                                                   |                                      |
| <p>24. FUNERAL DIRECTOR<br/><u>Thomas Jackson 2741 Dickson</u></p>                                                                                                                                                                                | <p>ADDRESS</p>                                                                                                         | <p>25. DATE RECD. BY LOCAL REG.<br/><u>7-2-63</u></p>                                                                                                               | <p>26. REGISTRAR'S SIGNATURE<br/><u>John B. Mumfry, M.D.</u></p>                    |                                                                                                                                                                              |                                                   |                                      |

**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 Leroy W. Dunnicutt

Licensed Embalmer No. 4523

P. O. Address 4251 WASHINGTON

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.