

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036383

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4777

FILED SEP 18 1963

VS 300 Rev. 4/59	DATE AMENDED
1	
23282	
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4 0	
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94344	
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12 86-0	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF Otto W. Theel

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

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 30YRS.	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 New Hope Rest Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1647 Jefferson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leonard Middle Powell Last Powell			4. DATE OF DEATH Month August Day 27 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Construction Worker		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (last birthday) 79 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11a. FATHER'S NAME John Powell		11b. MOTHER'S MAIDEN NAME Kate Powell	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Pre-Arrangement by Self Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Hypotatic Congestion DUE TO (c) Cardiac Decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 <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 checked="" 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 8-20-63 to 8-26-63 and last saw her him alive on 8-26-63 . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Otto W. Theel M.D.		22b. ADDRESS 4301 Main St. KCMo	22c. DATE SIGNED 8-27-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-29-63	23c. NAME OF CEMETERY OR CREMATORY Green Lawn	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Stine & McClure Und. Co., K. C., Mo.		25. DATE RECD. BY LOCAL REG. 8-28-63	26. REGISTRAR'S SIGNATURE Bessie Smith

Dr. D.W. Shree
4301 Main
Tue 1-3199
1:00 - 5:00

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

William M. Turner

Licensed Embalmer No.

4648

P. O. Address

Danvers City - Ms.

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.