

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

12382

1. PLACE OF DEATH

County Mississippi
Township Mississippi
City Charleston

Registration District No. 566
Primary Registration District No. 3030

File No. _____
Registered No. 29
St. _____ Ward _____

2. FULL NAME

Anna Bloomfield Poor
(a) Residence. No. Cypress St., _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas P. Poor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25 1844

7. AGE YEARS 85 MONTHS 3 DAYS 29 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Henderson County
(STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER Samuel B. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Harrisonburg
(STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scottsbluff
(STATE OR COUNTRY) Wy.

14. INFORMANT Annabelle Wally
(Address) Henderson Co. Mo.

15. Apr 25 1927 F. S. Smith
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/24 19 27

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1927, to April 24, 1927, that I last saw h. alive on April 23, 1927, and that death occurred, on the date stated above, at 4 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 cerebral hemorrhage
82 yrs.
74001
(duration) _____ yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) none known
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical symptoms
(Signed) R. H. Chapman M. D.
, 19 (Address) Charleston, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Dale Grove Cemetery DATE OF BURIAL 4/25 1927

20. UNDERTAKER Tate Salmon Funeral Co. ADDRESS Charleston Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

