

REC'D FEB 10 1939

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

744

Do not use this space.

## 1. PLACE OF DEATH

(a) County.....

Registration District No.....

(b) Township.....

Primary Registration District No.....

Registered No.....

(c) City St. Louis(d) Street No. City Hospital #1 St.(e) Length of residence in city or town where death occurred 10 yrs. 7 mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.2. PRINT FULL NAME Hugo H. Poisse(a) Residence, No. 4203 Prairie St. 10 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Single</b>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7, 1879

7. AGE YEARS <b>59</b>	MONTHS <b>8</b>	DAYS <b>17</b>	IF LESS than 1 day, ..... hrs. or ..... min.
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OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Clerk</b>
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>Railroad</b>
	10. Date deceased last worked at this occupation (month and year) <b>Jan 1939</b>
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holstein, Mo.13. NAME **Charles F. Poisse**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**15. MAIDEN NAME **Anna Huncker**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**17. INFORMANT **Mrs. Ed Kook**  
(ADDRESS) **4203 Prairie**18. BURIAL, CREMATION, OR REMOVAL PLACE **Warrenton, Mo.** DATE **1-26**, 19**39**19. FUNERAL DIRECTOR (NAME) **Albert H. Hoppe Inc.**  
(ADDRESS) **4700 Washington Blvd.**20. FILED **JAN 24 1939**  
**J. P. Budek**  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw h..... alive on....., 19...... Death is said

to have occurred on the date stated above, at 9:08 m.

The principal cause of death and related causes of importance were as follows:

Date of onset

*Pauline Hemorrhage*

Other contributory causes of importance:

*Coronary Hypertrophy*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify.....

(Signed) **Joseph M. Luman**(Address) **Deputy Coroner**

N. B.—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.

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*J. G. Sullivan*

Licensed Embalmer No. 1122

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**