

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

3228
 Do not use this space.

REC'D FEB 16 1939

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 55
 (b) Township Anderson Primary Registration District No. 6262
 (c) City Waverly (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1361

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

Sarah H. Pooy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 6A. IF MARRIED, WIDOWER, OR DIVORCED HUSBAND OF (OR) WIFE OF William H Pooy
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS 72 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 3, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1938, to Feb 3, 1939
 I last saw her alive on Feb 2, 1939. Death is said to have occurred on the date stated above, at 6 a. m.
 The principal cause of death and related causes of importance were as follows:

Influenza of Bronchae
Pneumonia

Date of onset _____

Other contributory causes of importance: _____

Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

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? none
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) B. G. Cant, M. D.
 (Address) Edwards

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

FATHER 13. NAME Joe Smith

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Miss Rudon

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Luther Pooy

18. BURIAL, CREMATION, OR REMOVAL PLACE Stanford DATE 2/4

19. FUNERAL DIRECTOR (NAME) C. Fay
 (ADDRESS) 1st cont no

20. FILED Feb 10 1939 M. V. Mumme
 Local Registrar.

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN REGISTER.

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

3228

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid
(b) Township Anderson
(c) City.....

Registration District No. 55
Primary Registration District No. 6252

Registered No. 1361

(e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number) yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah K. PAVY

(a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin. 72

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 10 1909 M. V. Murren Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-3 1909

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

Date of onset

Other contributory causes of importance:

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... 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? If so, specify. (Signed) B. E. Ellis, M. D. (Address) G. Lewis

THIS CERTIFICATE SHALL NOT BE VALID UNLESS IT BE RECEIVED AT THE BUREAU OF VITAL STATISTICS WITHIN THE TIME SPECIFIED THEREIN.

DUPLICATE

