DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34514

Registration District No. 701 Primary Registration District No. Registrar's No. 9052

1. PLACE OF DEATH:
(a) County 1008
(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County Crawford
(c) City or town Meadville (If outside city or town limits, write "RURAL") WR
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME George Adrian Poux 2.00
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Germaine
6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased June (Month) 14 (Day) 1893 (Year)

8. AGE: Years 46 Months 4 Days 10 If less than one day hr. min.

9. Birthplace Frenchtown, (City, town, or county) Pa. (State or foreign country)
10. Usual occupation Physcian
11. Industry or business
FATHER
12. Name Adrian Poux
13. Birthplace (City, town, or county) France (State or foreign country)
MOTHER
14. Maiden name Emma DeMaison
15. Birthplace Frenchtown, (City, town, or county) Pa. (State or foreign country)
16. (a) Informant's own signature Germaine Poux
(b) Address Frenchtown, Pa.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/24/39 (Month) (Day) (Year)
(c) Place: burial or cremation Frenchtown, Pa.
18. (a) Signature of funeral director Albert H. Hoppe.
(b) Address 4700 Washington Ave.
19. (a) OCT 24 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24 year 39 hour 11 minute A M.
21. I hereby certify that I attended the deceased from , 19 , to 10-24 , 1939 that I last saw him alive on 10-24 , 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Paralysis agitans	
Due to Terminal Pneumonia Hypostatic	
Due to unspecified	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Craniotomy for Paralysis agitans	
Of autopsy No	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other)
Address St. Louis Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-5-17-39
Rev. 5-17-39
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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.....

Licensed Embalmer No.....2971.....

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.