

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 - 1940
225

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6411

Registration District No. 225

Primary Registration District No. 5306

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Copper
(b) City or town Shelburne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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

8. (c) PRINT FULL NAME Eliza Pohlman 45

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 2 - 12 - 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Warren Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER
11. Industry or business _____
12. Name John Lohman
13. Birthplace Warren Co Missouri
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Terence Pohlman

(b) Address Prairie Home Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 20 - 40
(Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove Cem

18. (a) Signature of funeral director C. Albert Hornbeek

(b) Address Prairie Home Mo

19. (a) Feb - 12 - 40 (Date received local registrar) (b) W. Hoopes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Copper
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 18
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept 1
1939 to 1 - 18 1940
that I last saw her alive on 1 - 17 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis Pneumonia Duration 2 Mks

Due to Acidity 1 yr

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. L. Murch (M. D. or other) _____
Address Prairie Home Date signed 1-19-40

RECEIVED
District Health Officer No. 8
District File Number 3/5/40
Date Filed

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 comply with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6411
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 225

Primary Registration District No. 5306

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

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Saline Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Elizabeth Pohlman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 75 Months 11 Days 6 If less than one day _____ h. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

(c) Apr 4 - 1940 (b) W. N. Neuber (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cooper
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 18 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. L. Meredith (M.D. or other)

Address Prairie Home Date signed _____

SUPPLEMENTAL

