

Registration District No. 587

Primary Registration District No. 5405

Registrar's No. 2

1. PLACE OF DEATH

(a) County Bunklin County Mo  
(b) City or town Rural Clay Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 2

(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 Lucinda Pomax

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased Dec 26 1890  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 1 18 hr. min.

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

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

12. Name John Owens

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

14. Maiden name Caroline Cook

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

16. (a) Informant's own signature P. W. Hardy

(b) Address Hornersville Mo

17. (a) Remaf (b) Date thereof 2-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Remaf Cemetery

18. (a) Signature of funeral director M. Doran

(b) Address Bethel Mo

19. (a) 3/1/1940 (b) L. B. Cape  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bunklin

(c) City or town Clay Twp, 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 Feb day 14  
year 1940 hour 9 minute 45 P M.

21. I hereby certify that I attended the deceased from Feb 7  
1940 to Feb 14, 1940.

that I last saw her alive on Feb 14, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza  
hepatitis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Arterial sclerosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Wm H Bonds (M. D. or other) \_\_\_\_\_

Address Hornersville Mo Date signed 2-29-40

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.

RECEIVED

District Health Officer No. *340-685*

District File Number

Date Filed *3/6/40*

**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.....

*H. P. Groat*  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *H. P. Groat*  
.....

Licensed Embalmer No. *4106*

P. O. Address *Senath Mo*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 65-00Registration District No. 287Primary Registration District No. 3405-Registrar's No. 2

## 1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Clay  
(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

Lucinda Pomas3. (b) If veteran,  
name war.....3. (c) Social Security  
No.....4. Sex 75. Color or  
race w6. (a) Single, widowed, married,  
divorced w

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

Months

Days

If less than one day

69118

h..... min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....  
(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 Feb day 14  
year 1940 hour..... minute..... M.21. I hereby certify that I attended the deceased from.....  
....., 19....., to....., 19.....;  
that I last saw him..... alive on....., 19.....,  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Nephritis Chronic

Due to.....

arteriosclerosis

Due to.....

She had malgria at

Other conditions.....

(Include pregnancy within 3 months of death)

6 monthsMajor findings:  
Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 Van H. Bond (M. D. or other).....Address Hornersville Mo Date signed.....

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

MOTHER FATHER

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 65-007

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 297

Primary Registration District No. 2405

Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Clayton, Mo.  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME

Lucinda Pomas  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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 \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Feb day 14 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and year stated above.

Immediate cause of death Influenza  
Septicemic  
Chronic  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Wm N. Bond (M. D. or other) \_\_\_\_\_  
Address Harmerwell Mo Date signed \_\_\_\_\_

SUPPLEMENTAL