

FILED MAR 11 1940

Registration District No. _____

Primary Registration District No. 4201

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Gilman
(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 years, months or days)
In this community 69-4-20 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison
(c) City or town Gilman City
(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.

3. (a) PRINT FULL NAME CLARA EMMA POE, 503
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 22 year 40 hour 9 minute A. M.

4. Sex Male Female 5. Color or race White Black
6. (a) Single, widowed, married, divorced 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 00 2 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 1, 1939, to Feb 22, 1940
that I last saw her alive on Feb - 21, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 4 Days 20 If less than one day _____ hr. _____ min.

Immediate cause of death Chronic Nephritis
Due to _____
Due to _____

9. Birthplace: Waverly, Mo (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation House Keeper

11. Industry or business _____
12. Name Abraham Pol.
13. Birthplace State Ind.
14. Maiden name Martha Embick
15. Birthplace State of Ohio

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? _____

16. (a) Informant's own signature _____
(b) Address _____

17. (a) Burial (b) Date thereof 2-24-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Lawn Cemetery
18. (a) Signature of funeral director W. H. Haines
(b) Address Gilman City, Mo.

19. (a) 2-25-40 (b) Good Shepherd
(Date received local registrar) (Registrar's signature)

23. Signature J. E. WALKER (M.D. or other) D.O.
Address GILMAN CITY MO Date signed Feb 27

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

Rev. 5-17-39
1 X1931

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.

PHYSICIAN
Underline the cause to which death should be charged statistically

RECEIVED
District Health Officer No. 11,
District File Number 340-302
Date Filed MAR 9 1940

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. 6724

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 4201

Primary Registration District No. 338

Registrar's No. _____

R

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

1. PLACE OF DEATH

(a) County Harrison
(b) City or town Silman
(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 Clara Emma Poe

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

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Oct 2 1872
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 20 If less than one day _____ 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 _____

15. Birthplace _____ (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) 4/27/1940 (b) [Signature]
(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 22
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that last saw him _____ 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 _____

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 [Signature] (M. D. or other) _____
Address Silman City _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

8-6724