

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.

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

10503  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Cape Girardeau Registration District No. 125  
 (b) Township St. Francis Primary Registration District No. 3009 Registered No. 96  
 (c) City Cape Girardeau (d) Street No. St. Francis Hospital 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.

2. PRINT FULL NAME DOROTHY MARIE POBST  
 (a) Residence, No. ORAN R.F.D. MO St.  Oran, Mo  
 (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child.  
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child.  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5 1938  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 1 8 29.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child.  
 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) Oran R.F.D. Scott Missouri  
 FATHER 13. NAME Paul Pobst.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oran R.F.D. Mo. Scott County, D  
 MOTHER 15. MAIDEN NAME Irmina Gische.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oran R.F.D. Mo. Scott County, D  
 17. INFORMANT (ADDRESS) Paul Pobst Oran R.F.D. Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oran Catholic DATE Mar 4 40  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) P. J. Heisserer Co. Oran Missouri  
 20. FILED 3-4 1940 Jim Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 4 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 1/26 1940 to 3/4 1940  
 I last saw him alive on 3/4 1940 Death is said to have occurred on the date stated above, at 7:40 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Influenza pneumonia Date of onset 1/23/40  
118  
 Other contributory causes of importance:  
Heart disease 4 wk.  
acute nephritis 3 wks.  
 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 \_\_\_\_\_, 19\_\_\_\_  
 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) Chas. J. Heister M. D.  
 (Address) 630 York Hotel Cape Girardeau, Mo.

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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.....

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.**