

S. No. 2
-11-10-39
5-17-40
-1 X21-42

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16543**

JUN 15 1940
Registration District No. **7911**

Primary Registration District No. **1003**

Registrar's No. **4021**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days**
(Specify whether
In this community _____ ?
years, months or days)

8. (a) PRINT FULL NAME **MARIA N. POMEROY** **560**
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 **Wm. H. Pomeroy** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **November 7, 1852**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 - 5 27 hr. min.

9. Birthplace **Devonport, England**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER { 12. Name **William Newcombe**
18. Birthplace **England**
14. Maiden name **Elizabeth Oates**
16. Birthplace **England**

16. (a) Informant **Mrs. Hazel Helsher**
(b) Address **5011 Lansdowne Ave.**

17. (a) **Entombment** (b) Date thereof **May 6, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Mausoleum.**

18. (e) Signature of funeral director **Wm. M. Schumacher**
(b) Address **4834 Natural Bridge.**

19. (a) **MAY 5 1940** (b) **J. J. Odeh**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **14**
(If outside city or town limits write "RURAL")
(d) Street No. **5011 Lansdowne Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **3**,
year **1940** hour **8** minute **22 P.** M.

21. I hereby certify that I attended the deceased from **4/18/40**
_____ 19 _____ to **5/3/40** 19 _____
that I last saw her alive on **5/3/40** 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral thrombosis 1 day

Due to _____
Due to _____
Other conditions **arterio sclerosis**
(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) (c) Means of injury _____

28. Signature **O. J. Park** (M. D. or other) **md**
Address **Huntlands Rd** Date signed **5/4/40**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

John Fetter

Licensed Embalmer No. 3880

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.