

FILED DEC 16 1940

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 263

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

1. PLACE OF DEATH: *Adair*  
 (a) County *Adair*  
 (b) City or town *Kirksvill*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: *Grass-Smith Hospital*  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution *Eight weeks*  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME *Estella Poole*  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, divorced *Married*  
 6. (b) Name of husband or wife *Theodore S. Poole* 6. (c) Age of husband or wife if alive *80* years  
 7. Birth date of deceased *October 16, 1861*  
 (Month) (Day) (Year)

8. AGE: Years *79* Months *0* Days *19* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace *Macon, Missouri*  
 (City, town, or county) (State or foreign country)

10. Usual occupation *at home*

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

MOTHER FATHER { 12. Name *Thomas Sharp*  
 13. Birthplace *Ind.*  
 (City, town, or county) (State or foreign country)

{ 14. Maiden name *Margaret* *no data*  
 15. Birthplace *Kentucky*  
 (City, town, or county) (State or foreign country)

16. (a) Informant *Mrs. G. W. Herington*

(b) Address *Milan, Mo.*

17. (a) *Burial* (b) Date thereof *Nov. 7, 1940*  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Oakwood Cemetery*

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

(b) Address *Milan, Mo.*

19. (a) *Nov. 14/40* (b) *Spencer L. Freeman*  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State *Missouri* (b) County *Sullivan*  
 (c) City or town *Milan*  
 (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 *November* day *5*  
 year *1940* hour *9* minute *45* P. M.

21. I hereby certify that I attended the deceased from *Sept 6*, 1940, to *Nov 5*, 1940,  
 that I last saw her alive on *Nov 6*, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death *Fracture of Rt femur at hip*  
 Duration *2 mo*

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) *accident*  
 (b) Date of occurrence *Sept 6, 1940*  
 (c) Where did injury occur? *Milan Sullivan Mo*  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
*Home*

3 While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
 (e) Means of injury *slipped on city floor*

23. Signature *A. B. Ceraul* (M. D. \_\_\_\_\_)

Address *Manassas Mo* Date signed \_\_\_\_\_

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 12-40-2327

Date Filed DEC 14 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.....

Frank D. Schoene, Registered Apprentice No. ....  
working under my personal supervision.

Signed

Frank D. Schoene

Licensed Embalmer No. 2016

P. O. Address Milan, W.

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.