

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6518

State File No. _____

Registrar's No. 57

Registration District No. 125

Primary Registration District No. 3009

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Francis Hospital
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME LOTTIE POLSTON PATE

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

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

6. (b) Name of husband or wife LESLIE PATE 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased FEBRUARY 2, 1895
(Month) (Day) (Year)

8. AGE: Years 46 Months 0 Days 1 If less than one day hr. _____ min. _____

9. Birthplace EAST PRAIRIE, MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

12. Name DAVE POLSTON

13. Birthplace EAST PRAIRIE, MO
(City, town, or county) (State or foreign country)

14. Maiden name SUSIE HAYDEN

15. Birthplace EAST PRAIRIE, MO
(City, town, or county) (State or foreign country)

16. (a) Informant LESLIE PATE

(b) Address CHARLESTON, MO

17. (a) BURIAL (b) Date thereof 2-5-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE CHARLESTON, MO

18. (a) Signature of funeral director LAIR NUNNELEE

(b) Address CHARLESTON, MO

19. (a) 2-3-41 (b) John Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Mississippi
(c) City or town CHARLESTON
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 3RD
year 1941 hour 7 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction Bowel (Tumor) Congruent Tumor due to Tuberculosis

Due to Pneumonia

Other conditions 120
(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? 121

While at work? _____ (Specify type of place)

23. Signature L. B. Good (M. D. or other) _____

Address Cape Girardeau, MO Date signed _____

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 P. Hummel Jr

Licensed Embalmer No.

3857

P. O. Address

Charleston 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, fact should be so stated above.