

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

32765

State File No. \_\_\_\_\_

Registrar's No. 24

Registration District No. 839

Primary Registration District No. 6101

1. PLACE OF DEATH:  
 (a) County Stoddard  
 (b) City or town Rural - Bush Bluffs, Mo.  
 (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

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Stoddard  
 (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.

3. (a) PRINT FULL NAME SAMUEL ARNO POOLE

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

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

6. (b) Name of husband or wife Geletay 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
 (Month) (Day) (Year)

8. AGE: Years 45 Months \_\_\_\_\_ Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ohio County Kentucky  
 (City, town, or county) (State or foreign country)

10. Usual occupation farm laborer

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

12. Name Philip Poole

13. Birthplace Ohio Co. Kentucky  
 (City, town, or county) (State or foreign country)

14. Maiden name Eliza Hamilton

15. Birthplace Ohio Co. Kentucky  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mary Wright

(b) Address Marion St. Ma...

17. (a) Bury (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried in cemetery

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) 92441 (b) J. O. Brandon  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10  
 year 1941 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Hit by an automobile while walking on Highway 60 near Weston

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 August 10, 1941

(c) Where did injury occur? Highway near Stoddard Co.  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 103  
 (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Pres Hearn acting coroner (M. D. or other)  
 Address Bloomfield Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

03  
000

103  
00

RECEIVED

District Health Office No. 2,

District File Number 941-1319

Date Filed 9/26/41

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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, fact should be so stated above.**



