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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 20 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14098
Registrar's No. 86

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wilhite Convalescent Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

In this community 63 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY ELIZABETH POMIE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced / Married

6. (b) Name of husband or wife John Pomie

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 3 - 12 - 1881
(Month) (Day) (Year)

8. AGE: Years 63 Months 0 Days 14
If less than one day hr. min.

9. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name James Mockbee

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

14. Maiden name Mary Elizabeth Nichols

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Pomie

(b) Address Route 1, Columbia, Mo.

17. (a) Burial (b) Date thereof 3-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Parson Funeral Service
Columbia, Mo.

(b) Address

19. (a) 3-21-1944 (b) E. Anna H. Barber
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

(c) City or town Columbia 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route 1 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25
year 1944 hour 11:40 minute P. M.

21. I hereby certify that I attended the deceased from June 13 - 44
 19 to March 20 - 1944
that I last saw him alive on 3 - 25 - 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days

Due to Cardiac Hemorrhage
June 13 - 44

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

PHYSICIAN
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) No

(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? No (Specify type of place)
(e) Means of injury

23. Signature W. D. Dyar (M. D. or other) MA
Address Columbia, Mo. Date signed 3-27-44

1250

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 4-18-44

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 4122

P. O. Address Columbia

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.

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mary E. Pomie
3. (b) If veteran, name war 0 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 12
(Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ (Unless than one day) _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month March Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial 2 days
Duration

Due to Cerebral Hemorrhage
Jan 13 42

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

14098