

FILED JUL 14 1944

Registration District No. 387

Primary Registration District No. 4575

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community lifetime (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan 105
(c) City or town Milan (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joannah S. Poole

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John S. Poole 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased May 16 1860 (Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation At home

11. Industry or business _____

12. Name Ely Stanley
13. Birthplace Andersonville, Indiana (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth A. Brackett
15. Birthplace Louisville, Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Soloman M. Poole
(b) Address Milan, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood Cem. Milan, Mo.

18. (a) Signature of funeral director Schoene Funeral Service
(b) Address Milan, Mo., F.D. Schoene

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18
year 1944 hour 4 minute 37 A. M.

21. I hereby certify that I attended the deceased from June 16
1944 to June 18 1944;

that I last saw her alive on June 18 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
Hypostatic pneumonia

Due to Fractured right 12th rib

Due to _____

Other conditions (Includes 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) accident 105
(b) Date of occurrence June 18, 1944

Where did injury occur? Milan Sullivan Missouri (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
back yard of home

While at work? no (Specify type of place) (e) Means of injury fall

23. Signature Frank Felder, D.O. (M. D. or other)
Address Milan, Missouri Date signed 6/18/44

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

RECEIVED

District Health Officer No. 10

District File Number 7-44-1339

Date Filed JUL 13 1944

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

Frank D. Schoene

Licensed Embalmer No. 2916

P. O. Address Milam, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. _____

Registration District No. 381

Primary Registration District No. 4565

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Melan
(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 _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Jannah S. Pash
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 16 (Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days _____ If less 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 _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) July 6 1944 (b) Mrs. D. D. Green
(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 June Day _____
year 1944 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 _____

Due to _____
Due to _____

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

SUPPLEMENTARY

22707