

FILED FEB 7 1945

Registration District No. 319

Primary Registration District No. 6079

Registrar's No. 6

1. PLACE OF DEATH:

(a) County ST. GENEVIEVE
(b) City or town RURAL ST. GENEVIEVE T.S.
(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 COUNTY HOME
(Specify whether years, months or days)
In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. GENEVIEVE
(c) City or town RURAL
(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

3. (a) PRINT FULL NAME KATIE POE

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife JOHN POE 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased 1878
(Month) (Day) (Year)

8. AGE: Years 66 Months - Days - If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

12. Name MIKE RILEY
13. Birthplace IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name MARY RILEY
15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant John Poe

(b) Address St. Genevieve Mo

17. (a) Burial (b) Date thereof JAN 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Genevieve Mo

18. (a) Signature of funeral director Geo C. Bader

(b) Address St. Genevieve Mo

19. (a) Jan 25/45 (b) T. W. Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 19
year 1945 hour 1 minute 9 M.

21. I hereby certify that I attended the deceased from Jan 18 1945 to Jan 19 1945
that I last saw her alive on Jan 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 1/2

Due to arteriosclerosis ?

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations g3a

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?

(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 R. L. Leming (M. D. or other) 1/20/45

Address St. Genevieve Mo Date signed

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

500

706

RECEIVED

District Health Officer No. 4
District File Number 245-189
Date Filed 2-6-45

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 Francis Basler

Licensed Embalmer No. 1985

P. O. Address St. Genevieve 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.