

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE... THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
**STANDARD CERTIFICATE OF DEATH**

State File No. **4454**

**FILED MAR 1 1946**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3-050** Registrar's No. **19**

**1. PLACE OF DEATH:**  
**Adair.**  
(a) County **Adair.**  
(b) City or town **Kirksvilaen Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**416 S. Franklin St. /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **All her life.** (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo.** (b) County **Adair**  
(c) City or town **Kirksville,**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **416 S. Franklin**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Martha J. Poehlman,**  
**3. (b) If veteran,** name war \_\_\_\_\_  
**3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** **F.** **5. Color or race** **W.**  
**6. (a) Name of husband or wife** **Leonard F. Poehlman**  
**6. (b) Name of husband or wife** **Leonard F. Poehlman**  
**6. (c) Age of husband or wife if** **21, 1868.**  
**7. Birth date of deceased** **April**  
(Month) (Day) (Year)

**8. AGE:**  
Years **77** Months **8** Days **13**  
If less than one day  
hr. \_\_\_\_\_ min.

**9. Birthplace** **Adair County Missouri**  
(City, town, or county) (State or foreign country)  
**Housewife**

**10. Usual occupation** \_\_\_\_\_

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

**MOTHER FATHER**  
**12. Name** **Joseph D. Holman,**  
**13. Birthplace** **Illinois.**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Elizabeth Watson,**  
**15. Birthplace** **Polk Co. Missouri.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mamie Boussman**  
**(b) Address** **Springfield, Mo.**

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** **Jan. 6, 1946**  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** **Macon, Mo.**

**18. (a) Signature of funeral director** **Summers**  
**(b) Address** **Kirksville, Mo.**  
**19. (a) 1-16-46** (Date received local registrar) **(b) Kate Lambert** (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Jan** day **4**  
year **1946** hour **1** minute **30** M.  
**21. I hereby certify that I attended the deceased from** **Dec 3**  
**1945** to **Jan 4**, **1946**  
that I last saw her alive on **Jan 4**, **1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure**  
**Chronic Myocarditis**  
**Justial Renal Decembar**  
**Disease**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**Major findings:**  
Of operations **13/10**  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
**23. Signature** **J. P. Lambert** (M. D. or other) **DO**  
Address **Kirksville** Date signed **1/7/46**

**Duration** **60 days**  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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

3488

AUG 20 1947

RECEIVED  
District Health Officer No. 10  
District File Number 2-46-335  
Date Filed FEB 28 1946

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 *W. L. Summers*

Licensed Embalmer No. *2159*

P. O. Address *Winkaville 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.