

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4169**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 weeks 3 Days**
(Specify whether
In this community **23 Years**
years, months or days)

3. (a) PRINT
FULL NAME

Agatha Poole

3. (b) If veteran, name war **no** 3. (c) Social Security No. **490-03-3475**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Emory Poole** 6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **Oct. 28, 1909**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 **6** **8** hr. min.

9. Birthplace **Reily Lake** **ILL.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER
12. Name **Joseph Kintz**
13. Birthplace **Unknown** **ILL.**
(City, town, or county) (State or foreign country)
14. Maiden name **Alice Wessel**
15. Birthplace **Unknown** **ILL.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emory Poole**
(b) Address **2913 Sullivan Ave**

17. (a) **Burial** (b) Date thereof **5-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Goodhart & Goodhart**
(b) Address **2228 St. Louis Ave**

19. (a) **MAY 8 1946** (b) **J. F. Bradock**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2913 Sullivan Ave**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **6**
year **1946** hour **10** minute **20** a. M.

21. I hereby certify that I attended the deceased from **Sept. 7, 1945** to **May 6, 1946**
that I last saw h. **ex** alive on **May 6, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** Duration **12 hrs.**

Due to **Rheumatic Heart, embolism of aortic tibial artery, life span 6 weeks**

Due to **Rheumatic Fever** **1 yr 9 mos.**

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?

23. Signature **Arthur Brinkman** (M.D. or other) **M.D.**
Address **2202 University St.** Date signed **5/7/46**

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 Marie A. Cashion
Licensed Embalmer No. 3949
P. O. Address St. Louis, 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.