No. 2
-9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20949

State File No.

FILED JUL 8 1946

Registration District No. 208 Primary Registration District No. 4317 Registrar's No. 124

1. PLACE OF DEATH:
(a) County MADISON
(b) City or town MARQUAND MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NONE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Madison
(c) City or town Marquand
(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 William Pinkney Pope
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of ~~husband or~~ wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 2 (Day) 1860 (Year)

8. AGE: Years 85 Months 9 Days 5 If less than one day hr. min.

9. Birthplace MARQUAND MO (City, town, or county) (State or foreign country)
10. Usual occupation FARMER
11. Industry or business
MOTHER FATHER
12. Name George Pope
13. Birthplace Can't say (City, town, or county) (State or foreign country)
14. Maiden name Can't say
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant DANIEL H. MOKSER
(b) Address MARQUAND MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof June 8 1946 (Month) (Day) (Year)
(c) Place: burial or cremation MOKSER CEMETERY
18. (a) Signature of funeral director [illegible]
(b) Address Marquand MO
19. (a) 6-13-1946 (Date received local registrar) (b) Florence Hicks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1946 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased ~~from~~ For years, ~~last~~ ~~March~~ ~~1946~~ to June 7 1946 that I last saw him alive on May 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
~~Pulmonary Tuberculosis~~	~~[illegible]~~
Chronic Nephritis	18 months
Due to Arterio Sclerosis	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death) Labor Pneumonia - 3 weeks before 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address 33 W. Main Fredericktown Date signed 6-8-46

187 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 46 - 2283

Date Filed 7-6-46

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 206 Primary Registration District No. 4317 Registrar's No. 12 X

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Marquand
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Madison
(c) City or town Marquand
(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 William P. Pope
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased Sept (Month) 2 (Day) 1866 (Year)
8. AGE: Years 85 Months 9 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) Florence Wickin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1946 hour P.M. minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

20949