

FILED JUL 22 1947

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 210

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(c) Name of hospital or institution St. Francis
(d) Length of stay: In hospital or institution 9 Days
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County SCOTT
(c) City or town ORAN, R.F.D. 0
(d) Street No. 0
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME

ANDREW POBST

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife THERSIE (c) Age of husband or wife if alive 69 years

7. Birth date of deceased MAY 2 1874

8. AGE: Years 73 Months 1 Days 28

9. Birthplace NEW HAMBURG MO

10. Usual occupation FARMER

11. Industry or business

12. Name JOS. POBST
13. Birthplace DONT KNOW
14. Maiden name CLARA GERST
15. Birthplace DONT KNOW

16. (a) Informant MRS. ANDY POBST
(b) Address ORAN MO

17. (a) BURIAL (b) Date thereof JULY 2 1947
(c) Place: burial or cremation ORAN MO

18. (a) Signature of funeral director
(b) Address Oran MO

19. (a) 7-8-1947 (b) C. O. Summer

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 30th year 1947 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from June 20 1947 to June 30 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon

Due to Metastatic Carcinoma

Due to Mesenteric

Other conditions (Include pregnancy within 3 months of death)

Major findings: Ca of transverse Colon, metastatic Ca to mesenteric

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?
(e) While at work?
(f) Means of injury

23. Signature: [Signature] (M. D. or other) [Signature]
Address: Cape Girardeau MO Date signed: [Signature]

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

Duration

1 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4

District File Number 747-926

Date Filed 7-19-47

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 Raymond Lewis

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.