

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. **35482**  
Registrar's No. **2312**

Registration District No. **379**

Primary Registration District No. **6076**

**1. PLACE OF DEATH:**

(a) County **ST. LOUIS**  
(b) City or town **K**  
(c) Name of hospital or institution:  
**9702-St. Charles Road**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **One year**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Roy Silas Poe**

3. (b) If veteran, name war **None** 3. (c) Social Security No.

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

6. (b) Name of husband or wife **Nora E.** 6. (c) Age of husband or wife if alive **54** years

7. Birth date of deceased **Sept. 7 1885**  
(Month) (Day) (Year)

8. AGE: Years **63** Months **1** Days **9** If less than one day hr. min.

9. Birthplace **Grafton Ill.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown**  
13. Birthplace **Unknown**  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Nora E. Poe**  
(b) Address **9702-St. Charles Rd-Overland, Mo.**

17. (a) **Burial** (b) Date thereof **10-19-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Lake Charles Park**

18. (a) Signature of funeral director **Blumstein**  
(b) Address **2504-Woodson Rd-Overland, Mo.**

19. (a) **10-18-48** (b) **Beck**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **Overland Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **9702-St. Charles Road**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Oct.** day **16**  
year **1948** hour **11** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **DIED WITHOUT MEDICAL ATTENDANCE**, 19  
that I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cause unknown**

Due to \_\_\_\_\_

Due to **Dose**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?

While working? (Specify type of place) \_\_\_\_\_  
23. Signature **Beck** (M. D. or other) \_\_\_\_\_  
**COMMISSIONER OF HEALTH** Date signed **10-19-48**  
Address \_\_\_\_\_

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

76  
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**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 3454

....., Registered Apprentice No.....  
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14, 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.**