

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3134

State File No. 527  
Registrar's No.

BIRTH NO.		REG. DIST. NO. 319		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 weeks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 927 1/2 N. Pendleton Avenue
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital.			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Ambrose b. (Middle) Poe c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 1-16-49		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 1889	9. AGE (in years last birthday) Abt. 60	IF UNDER 1 YEAR Months Days IF UNDER 48 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10b. KIND OF BUSINESS OR INDUSTRY Private family	11. BIRTHPLACE (State or foreign country) Jackson, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME George Poe		13b. MOTHER'S MAIDEN NAME Lyla Collier		14. NAME OF HUSBAND OR WIFE Georgia Poe de'd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Emma Todd, 824 Edgemont St., Ind., Ind.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  ANTECEDENT CAUSES  DUE TO (b)  DUE TO (c)		MEDICAL CERTIFICATION Ruled a heart disease, Pulmonary infarct, Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
18. CAUSE OF DEATH (continued)	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		417X 95-6		
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION No operation		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 12-30-48, 19, to 1-16, 1949, that I last saw the deceased alive on 1-16, 1949, and that death occurred at 10:05 a.m., from the causes and on the date stated above.					
23a. SIGNATURE FR Bradley M.D.			23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 1/16/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/20/49	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem	24d. LOCATION (City, town, or county) (State) St Louis County Mo.		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 19 1949		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas. J. Gates, 4107 Finney Ave.			

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed..... *John R. Cunningham* .....

Signed.....  
Student Embalmer

Licensed Embalmer No..... *4476* .....

P. O. Address *4107 Frinney Av* .....

**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.