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

FILED AUG 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28800

BIRTH NO. _____ REG. DIST. NO. 372 PRIMARY REG. DIST. NO. 6264 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY Webster
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Seymour Rt. 1
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Seymour Rt. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Webster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Seymour Rt. 1 1120
d. STREET ADDRESS (If rural, give location) Seymour Rt-1

3. NAME OF DECEASED (Type or Print)
a. (First) Wade
b. (Middle) Hampton
c. (Last) Poole

4. DATE OF DEATH (Month) (Day) (Year) Aug. 14, 1955

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 5, 1888
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer
11. BIRTHPLACE (State or foreign country) Wright Co, Mo.
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Hiram Poole
13b. MOTHER'S MAIDEN NAME Sarah Bryant
14. NAME OF HUSBAND OR WIFE Goldie Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give was or dates of service)
16. SOCIAL SECURITY NO. 431-24-6791
17. INFORMANT'S SIGNATURE OR NAME Mrs Goldie Poole, ADDRESS Seymour Rt. 1

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure (Chronic) — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) 4341

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 13, 1955, *to* Aug 13, 1955, *that I last saw the deceased alive on* Aug 13, 1955, *and that death occurred at* 10P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] DO 2
23b. ADDRESS Mansfield Mo
23c. DATE SIGNED 8/18/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/17/55
24c. NAME OF CEMETERY OR CREMATORY No. 5 Cemetery
24d. LOCATION (City, town, or county) (State) Webster Co Mo

DATE REC'D BY LOCAL REG. 8-20-1955
REGISTRAR'S SIGNATURE Gilbert Jones 343
25. FUNERAL DIRECTOR'S SIGNATURE Don G. Ferrell, ADDRESS Mansfield Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Don G. Ferrell

Licensed Embalmer No. 4847

P. O. Address Mansfield,

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

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