FILED DEC 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36687

BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 5527 Registrar's No. 80

1. PLACE OF DEATH
a. COUNTY: Hickory
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Tyler Township
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): 6 miles East of Elkton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Hickory
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Tyler Township
d. STREET ADDRESS (If rural, give location): 6 miles East of Elkton

3. NAME OF DECEASED (Type or Print)
a. (First): Ida
b. (Middle): Virginia
c. (Last): Poe

4. DATE OF DEATH (Month) (Day) (Year): Dec 3 - 1955

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 28 - 1877
9. AGE (In years last birthday): 78. IF UNDER 1 YEAR: Months 2 Days 5 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Atchison Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Thomas Napier
13b. MOTHER'S MAIDEN NAME: Mary Hickman
14. NAME OF HUSBAND OR WIFE: George Poe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Oma Johnson - Wilder Idaho ADDRESS

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) Sarcoma of left Temple — INTERVAL BETWEEN ONSET AND DEATH: Two years

ANTECEDENT CAUSES

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

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 191X

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* July 10, 1954, *to* Dec 3, 1955, *that I last saw the deceased alive on* Dec 2, 1955, *and that death occurred at* 12:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. L. Briggs, D.O.
23b. ADDRESS: Wheatland, Mo
23c. DATE SIGNED: 12-7-55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 8-1955
24c. NAME OF CEMETERY OR CREMATORY: Crutsinger Cemetery
24d. LOCATION (City, town, or county) (State): Urbana, Mo

DATE REC'D BY LOCAL REG.: 12-8-1955
REGISTRAR'S SIGNATURE: May Johnson 464
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Gilbert Hathaway - Wheatland Mo

(Licensed Embalmer's Statement on Reverse Side)

NOV 12 1964

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 Chas Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland, Wy

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

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