

FILED NOV 19 1957

STATE FILE NUMBER  
42470  
10735  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

V. S. 300  
Rev. 1-57

Securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP #.</b>		Length of stay in lb <b>4.</b>	d. STREET ADDRESS (If outside, give location) <b>2247 E. 2101 Keokuk St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD POOLE</b>			4. DATE OF DEATH Month Day Year <b>NOV. 8, 1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15-1903</b>
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alexian Bros. Hospital</b>	11. BIRTHPLACE (City and state or country) <b>Bath, South Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Edward Poole</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Estelle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>253-16-0235</b>	17. INFORMANT Address <b>Mrs. Estelle Poole, 2101 Keokuk St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO (b) <b>Epilepsy, I. hypothermia</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>353.3</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>11/3/57</b> to <b>11/8/57</b> and last saw her alive on <b>11/8/57</b> Death occurred at <b>8:55 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE - (Name or title) <b>Joseph Drew Callahan M.D.</b>	
22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>11/9/57.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-11-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>C. Hoffmeister Undtk. &amp; L. Co.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 12 57</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>M. J. B.</b>

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill C. Brannon

Licensed Embalmer No. 4764  
P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.