

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019526
STATE FILE NUMBER

2. 4874
Registration No.

FILED JUN 1 1959 Registration District No. Primary Registration District No. Registration No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hosp. Inc.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1112 N. 9th St Apt 203 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Nellie Middle - Last Poe			4. DATE OF DEATH Month May Day 18 Year 1959	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1881	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Georgetown, Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jonathan B. Torbert		13b. MOTHER'S MAIDEN NAME Cornelia LaFleur	14. NAME OF HUSBAND OR WIFE Frank Poe
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Bessie Quinn 1112 N. 9th St. Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia		INTERVAL BETWEEN ONSET AND DEATH 7 years
Conditions, if any, which gave rise to above cause (a), steering the underlying cause lost.	DUE TO (b) Myeloid sclerosis	
	DUE TO (c) 292.3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour Month, Day, Year p.m.
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from Death occurred at March 1959 to May 18, 1959 and last saw her alive on May 17, 1959 12:00 Noon m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) Masao Okamoto M.D.	22b. ADDRESS 607 N. Grand	22c. DATE SIGNED 5/18/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)	23b. DATE 5-20-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Commerce, Mo.
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24. FUNERAL DIRECTOR Kreighbauser Funeral Home	ADDRESS St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. MAY 19'59	26. REGISTRAR'S SIGNATURE Mrs. Pearl Smith, M.D.
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Doctor, coroner, etc. must use only standard nomenclature in Year 10. 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

300
1-57
592

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 *Edwin A. Bernath*

Licensed Embalmer No. *3024*

P. O. Address

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.