

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035296**

**FILED VS NOV 9 1959**

042 1000 1104

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>			Length of stay in 1b <b>3 yrs.</b>		c. CITY OR TOWN <b>Gower</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hillside Rest Home</b> <b>718 North 7th St.,</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>none</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Roasline</b> Middle <b>C.</b> Last <b>Poe</b>				4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1959</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Buchanan Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James C. Corington</b>			13b. MOTHER'S MAIDEN NAME <b>Mary A. Fitch</b>			14. NAME OF HUSBAND OR WIFE <b>Curtis Poe</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>486-30-4743</b>		17. INFORMANT Address <b>Mrs. Linerie Bland, Gower, Missouri</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>							<b>10 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <b>Coronary atherosclerosis</b>							<b>2-3 yrs</b>	
DUE TO (c) <b>Generalized arteriosclerosis</b>							<b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <b>Dec. 1957</b> to <b>Oct. 31, 1959</b> and last saw her <b>Oct 30, 1959</b> Death occurred at <b>1:35</b> A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John P. Mabrey M.D.</b>				22b. ADDRESS <b>Plattburg, Mo.</b>		22c. DATE SIGNED <b>Nov. 3, 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Nov. 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Gower, Missouri</b>			
24. FUNERAL DIRECTOR <b>Minickoff Herman Inc.</b> <b>BY EAL</b>			ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 5, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

DOCUMENT

J.P. Mabrey, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Albert B. Harrington

Licensed Embalmer No. 3258

P. O. Address A. Joseph

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.