

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

26537

Do not use this space.

DESD AUG 19 1939

**1. PLACE OF DEATH**

(a) County Phelps  
 (b) Township St. James  
 (c) City \_\_\_\_\_

Registration District No. 678  
 Primary Registration District No. 3904

Registered No. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ♀ 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. E. Pohl

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-21-1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
59      2      18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) 6-30-38  
 11. Total time (years) spent in this occupation 31 7/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stein Prairie, Mo.

FATHER 13. NAME T. H. Milloughby

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis

MOTHER 15. MAIDEN NAME Mathilda Wallace

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co., Mo.

17. INFORMANT (ADDRESS) J. E. Pohl, St James

18. BURIAL, CREMATION, OR REMOVAL PLACE Shepherd Hill DATE 7-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. E. Tichler, St James, Mo.

20. FILED 8-3- 1939 Elsie B. Hawk Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-9- 1939

22. I HEREBY CERTIFY, That I attended deceased from July 27 1939, to July 8 1939

I last saw h. alive on July 7 1939. Death is said to have occurred on the date stated above, at 7:00 P.M.  
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage  
1912  
 Other contributory causes of importance:  
Fracture of left femur

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Accident Date of injury 2-27-38  
 Where did injury occur? Home St James, Mo.  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Caught foot on rug - fell -  
 Nature of injury Fracture of femur

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) William H. Starnes, M. D.  
 (Address) St James, Mo.

I X 16685  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED  
District Health Officer No. 5,  
File Number 839-25  
Date 8-18-29

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.....

Orrel E. Lickleiter, Registered Apprentice No.....  
working under my personal supervision.

Signed Orrel E. Lickleiter

Licensed Embalmer No. 3546

P. O. Address St. James, 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 this body is not embalmed, above space should be left blank.