

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21469

State File No. _____

Registrar's No. _____

Registration District No. 147

Primary Registration District No. 5211

1. PLACE OF DEATH

(a) County Cass
(b) City or town Archie Mo R.R. Route
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2-0
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 70 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Archie Mo P.O. Road
(If outside city or town limits, write "RURAL")
(d) Street No. 6 miles west of Archie
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Margaret Emeline Poland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife L. B. Poland 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased 1-18-1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Brownburg Henderson Co Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Daniel S. Brown
13. Birthplace Brownburg Ky
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Thomas
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Poland
(b) Address Archie Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-40
(Month) (Day) (Year)
(c) Place: burial or cremation Harrisonville Mo

18. (a) Signature of funeral director Arthur B...
(b) Address Archie Mo

19. (a) 6-5-40 (Date received local registrar) (b) Mrs Donald Deir (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3 year 1940 hour 11 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to June 3 1940

that I last saw her alive on June 3 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence ✓
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 140
While at work? (Specify type of place) (e) Means of injury ✓
23. Signature B. B. Fout (M. D. or other) ✓
Address Archie Mo Date signed 6/3

Duration 2 hrs.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

522

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Robert W. Hinson

Licensed Embalmer No. *3970*

P. O. Address *Darlington*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21469

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 147

Primary Registration District No. 52.11

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Meritt T. P.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Margaret Emeline Poland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

20. DATE OF DEATH Month June day 3 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis

Due to Supra Cerebral haemorrhage
bleed in 1/2 hours

Due to _____

Other conditions (Include pregnancy within 3 months of death) 87 W

Major findings: Of operations _____ Of autopsy _____

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) _____ (b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State) _____ (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature B. B. Tout (M. D. or other) _____ Address Archie Date signed June 4

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

