

FILED APR 20 1944

Registration District No. 209

Primary Registration District No. 3073-5766

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural, Miller Township
(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)
(d) Length of stay: In hospital or institution 18 years (Specify whether years, months or days)
In this community 18 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Christina Poppe

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John C.F. Poppe 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased October 27 1888
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 20 If less than one day hr. min.

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

10. Usual occupation House wife

MOTHER } 11. Industry or business

Nicholas Staff

12. Name Nicholas Staff
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name No record

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

16. (a) Informant John Poppe

(b) Address Hannibal, Mo Rt #1

17. (a) Removal (b) Date thereof 5/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenmount Cemetery

18. (a) Signature of funeral director Lewis McQuincy, Ill.

(b) Address Palmyra, Mo.

19. (a) 3-18-44 (b) R. H. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Miller Township
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17, 1944
year 1944 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 8 1944 to March 17 1944
that I last saw her alive on March 15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Embolicism
Due to Pelvic Papistomy March 6
Duration 4

Due to /

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations /
Of autopsy /

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Hannibal Mo (M. D. or other) March 17
Address Hannibal Mo Date signed March 17

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..... *Joseph Lewis*
Licensed Embalmer No. *2382*
P. O. Address..... *Palmyra W*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 1010

Registration District No. 209

Primary Registration District No. 6766

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Rural Meller Twp
(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)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Christina Pezze
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 Oct. 27
(Month) (Day) (Year)
8. AGE: Years 55 Months 4 Days _____
(less than one day) 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I saw him _____ on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death embolism

Due to Fibrosis uterus, gas
Due to Pelvic Laparotomy
3-6-44

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

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed _____

SUPPLEMENTARY

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

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