

S. No. 2
M-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16394

State File No. _____

Registration District No. 42

Primary Registration District No. 5132

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Rural - Wayne Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1/2 mile South of Halls, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1/2 mile South of Halls, Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary C. Poage

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Stephen E. Poage
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 26 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 7 8 _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Daniel Miller
13. Birthplace unknown Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Florence E. Bowman
15. Birthplace unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Stephen E. Poage
(b) Address Halls, Missouri

17. (a) Burial (b) Date thereof 6/7/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah, Mo.

18. (a) Signature of funeral director Heater Bube & Bowman
(b) Address 319 So. 10th Street

19. (a) 6/6/45 (b) Allen T. Peckle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1945 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 4, 1945, to June 4, 1945
and that death occurred on the date and hour stated above.

that I last saw him alive on June 4, 1945
Immediate cause of death Cerebral Hemorrhage Duration 2 hr
Ch. Hypertension 1 yr

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations gsw
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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)
(c) Means of injury gsw

23. Signature A. B. [unclear] (M. D. or other)
Address 134 [unclear] Date signed 6/6/45

1377

(Licensed Embalmer's Statement on Reverse Side)

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

11
00
00

Dr. G. R. Zimmerman
234 Illinois

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 Frank A. Bowman
Licensed Embalmer No. 1410
P. O. Address St. Joseph 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, fact should be so stated above.