No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 30 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2142

State File No.

Registration District No. 310 Primary Registration District No. 3088 Registrar's No. 18

1. PLACE OF DEATH

(a) County St. Charles

(b) City or town St. Charles, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital - St. Charles Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether
In this community 72 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery 70

(c) City or town Montgomery City 1
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Lucy Lee Pool

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased April (Month) 24 (Day) 1865 (Year)

8. AGE: Years 82 Months 8 Days 18 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Krueger 4
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Sophia Gauldman
15. Birthplace Unknown (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Ira Pool
(b) Address New Florence, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof January 10, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Montgomery City, Mo.

18. (a) Signature of funeral director Schlanker Mortuary
(b) Address Montgomery City, Mo.

19. (a) Jan 27-48 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 8
year 1948 hour 10:45 minute a. M.

21. I hereby certify that I attended the deceased from 12/20, 1947 to 1/8, 1948
that I last saw her alive on 1/8, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	3 days
Due to Bed ridden for	5 wks
Due to	
Other conditions Fracture l. hip. (Include pregnancy within 3 months of death)	5 wks.

Major findings:
Of operations none
Of autopsy none

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

22. If death was due to external causes, fill in the following: 10
(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?
(Specify type of place)
While at work? (e) Means of injury 0

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Signature B. L. Neubauer (M. D. or other) M.D.
Address St. Charles Mo. Date signed 1/10/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
Duplicate File Number
Date Filed JAN 29 1948

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. E. Boone Schlunker

Licensed Embalmer No. 4136

P. O. Address. Montgomery City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEA...

STANDARD CERTIFICATE OF DEATH

State File No. Fe N

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 18

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town St Charles
(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)

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

3. (a) PRINT FULL NAME Lucy Lee Pool

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 wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 2 (Day) 1865 (Year)

8. AGE: Years 82 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) No. (State or foreign country)

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 8
year 1948 hour minute M.

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

	Duration
Immediate cause of death	
Due to Hypostatic pneumonia	1 wk.
Due to Being bed ridden by fractured femur	4 wks
Other conditions Paralysis agitans (Include pregnancy within 3 months of death)	years

Major findings:
Of operations
Of autopsy

186 A
14

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) accident
(b) Date of occurrence 12/1/47
(c) Where did injury occur? In her yard (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? about her home (Specify type of place)
While at work? yes (e) Means of injury Fall

23. Signature B. L. Neuberger (M. D. or other)
Address St. Charles Mo. Date signed 2/7/48

N°E

S-2142