

FILED MAY 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17599
4179

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
b. CITY (If outside corporate limits, write RURAL and give township)				a. STATE Missouri		b. COUNTY	
c. LENGTH OF STAY (In this place)				c. CITY (If outside corporate limits, write RURAL and give township)		17 9 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, 0				d. STREET ADDRESS (If rural, give location)		4021 Enright	
3. NAME OF DECEASED (Type or Print)		a. (First) VIRGINIA		b. (Middle) DAISY		c. (Last) POOLE	
4. DATE OF DEATH		May 7, 1949		5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		Widow		8. DATE OF BIRTH		Unknown--1883	
9. AGE (In years last birthday)		Abt. 65		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housekeeper		Private Family		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
New Orleans, Louisiana		U.S.A.		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
Unavailable		Unavailable		14. NAME OF HUSBAND OR WIFE		Joe Poole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		No		16. SOCIAL SECURITY NO.		None	
17. INFORMANT'S SIGNATURE OR NAME		Enola Lewis, Patterson, Louisiana		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary failure</u>		DUPLICATE				12 years	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS					
DUPLICATE		DUPLICATE					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) :		(COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		302 023X	
22. I hereby certify that I attended the deceased from 1916, 19, to May 7, 1949, that I last saw the deceased alive on May 7, 1949, and that death occurred at 2:05 pm., from the causes and on the date stated above.							
23a. SIGNATURE H.R. Bradley				23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 5/7/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Burial		5/11/49		Greenwood Cemetery		St. Louis, Missouri	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
MAY 10 1949		J. B. Fasater		Chas. J. Gates, 4107 Finney Avenue			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

James C. [Signature]

Licensed Embalmer No. ~~4478~~ 4259

P. O. Address 4107 Finney Avenue

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.