No. 300
10.48

FILED OCT 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29595

State File No.

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 5228 Registrar's No. 145

1906

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

1. PLACE OF DEATH
a. COUNTY: Cass
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gunn City
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Cass
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gunn City
d. STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print)
a. (First): Rose
b. (Middle): Ethel
c. (Last): Poil

4. DATE OF DEATH (Month) 9 (Day) 21 (Year) 1949

5. SEX: Fem.
6. COLOR OR RACE: Wh.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-13-1887
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months 9, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (State or foreign country): Rochester Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Henry C Myers
13b. MOTHER'S MAIDEN NAME: May Truesdale
14. NAME OF HUSBAND OR WIFE: A. L. Poil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: A. L. Poil — ADDRESS: Gunn City Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cystitis — 1 yr
DUE TO (c): ✓

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ✓ — 331X

19a. DATE OF OPERATION: ✓
19b. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☑

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) m.: ✓
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1949, *to* Sept 15, 1949, *that I last saw the deceased alive on* Sept 15, 1949, *and that death occurred at* 5P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Hmcm Ames DO
23b. ADDRESS: Garden City Mo
23c. DATE SIGNED: 9/24/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/24/49
24c. NAME OF CEMETERY OR CREMATORY: Gunn City
24d. LOCATION (City, town, or county): Gunn City (State): Mo

DATE REC'D BY LOCAL REG.: Sept 24, 1949
REGISTRAR'S SIGNATURE: Laura J. Jones 51 0
25. FUNERAL DIRECTOR'S SIGNATURE: A. D. Hartzler — ADDRESS: East Lynne Mo.

(Licensed Embalmer's Statement on Reverse Side)

T 5 1949

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 A. D. Hartzler

Licensed Embalmer No. 2717

P. O. Address East Lynne 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.