

FILED NOV 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36058

BIRTH NO. _____		REG. DIST. NO. 381		PRIMARY REG. DIST. NO. 4515		Registrar's No. _____	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY Sullivan		b. CITY (If outside corporate limits, write RURAL and give township) Milan		a. STATE Mo		b. COUNTY Sullivan	
c. LENGTH OF STAY (in this place) 89 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Milan		d. STREET ADDRESS _____		(If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		3. NAME OF DECEASED		4. DATE OF DEATH		5. SEX male	
a. (First) Theophilus		b. (Middle) Soloman		c. (Last) Poole		6. COLOR OR RACE white	
(Type or Print)		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 5-22-1860		9. AGE (In years last birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Hardware		11. BIRTHPLACE (State or foreign country) Milan - 1110 D		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Soloman Poole		13b. MOTHER'S MAIDEN NAME Margaret Webb		14. NAME OF HUSBAND OR WIFE T.S. Poole Jr		17. INFORMANT'S SIGNATURE OR NAME Milan Mo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. ADDRESS Milan Mo		18. CAUSE OF DEATH	
(If yes, give war or dates of service)		18. CAUSE OF DEATH		MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		DUE TO (b) Comatose					
		DUE TO (c) Senility					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Locked bowels and prostate hypertrophy		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION Dec 12 1949		19b. MAJOR FINDINGS OF OPERATION Malignant B		21a. ACCIDENT, SUICIDE, HOMICIDE		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?	
22. I hereby certify that I attended the deceased from 9-8 1949, to _____, 19____, that I last saw the deceased alive on 11-2, 1949 and that death occurred at 9:30 m., from the causes and on the date stated above.							
23a. SIGNATURE Joseph E. Priardo				23b. ADDRESS Milan Mo		23c. DATE SIGNED 11-8-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-5-49		24c. NAME OF CEMETERY OR CREMATORY Oakwood Cem		24d. LOCATION (City, town, or county) (State) Milan Mo	
DATE REC'D BY LOCAL REG. Nov. 12-1949		REGISTRAR'S SIGNATURE Mrs. H. B. Harms		25. FUNERAL DIRECTOR'S SIGNATURE Schweizer		ADDRESS Milan - 1110	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 14 1949  
District Health Officer No. 10  
District File Number 11-49-18  
Date Filed NOV 14 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.....

*Dwight Schwein*

Licensed Embalmer No. 2667

P. O. Address Ular - no.

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.