

No. 300
10.48

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28621
7112

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). a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN NAMEOKI TWP.	
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH		d. STREET ADDRESS (If rural, give location) 1916 5 th ILLINOIS	

3. NAME OF DECEASED (Type or Print)	a. (First) Rhoda	b. (Middle) E. V. A. C.	c. (Last) Pomeroy	4. DATE OF DEATH (Month) (Day) (Year) AUG 8 1951
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB 22 - 24 - 74	9. AGE (In years last birthday) Months Days 27 - 74	IF UNDER 1 YEAR Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MOUNTAIN GROVE MO	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE JAMES T
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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. No	17. INFORMANT'S SIGNATURE OR NAME Rev. M. M. Brewer	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 yrs 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute thrombosis of the lungs</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Quarrel arteriosclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia, by lower lobe</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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 332X
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22. I hereby certify that I attended the deceased from January, 1951 to 8-8, 1951, that I last saw the deceased alive on 8-8, 1951, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul O. Silverman, M.D.</u>	23b. ADDRESS <u>508 N Grand</u>	23c. DATE SIGNED <u>8-8-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>AUG 8 - 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>REMOVAL MADISON</u>	24d. LOCATION (City, town, or county) (State) <u>Madison IL</u>
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DATE REC'D BY LOCAL REG. <u>AUG 9 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Madison</u>
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Francis J. Lahey

Licensed Embalmer No. *2792*

P. O. Address *Madison Ill*

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.