

No. 3007 FILED JAN 26 1953

10-48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2729

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3054		Registrar's No. 17	
1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>			
b. CITY OR TOWN <b>St. Charles</b>		c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>		d. STREET ADDRESS (If rural, give location) <b>1018 Clay St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1018 Clay St.</b>				d. STREET ADDRESS (If rural, give location) <b>1018 Clay St.</b>			
3. NAME OF DECEASED a. (First) <b>ANNA</b> (Type or Print)		b. (Middle) <b>MARIE</b>		c. (Last) <b>POESE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 17, 1953</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>January 1, 1881</b>	
9. AGE (In years last birthday) <b>72</b>		10. UNDER 12 mos. Hours <b>0</b>		11. UNDER 12 mos. Days <b>16</b>		11. BIRTHPLACE (State or foreign country) <b>St. Charles, Missouri</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>St. Charles, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Weidey</b>		13b. MOTHER'S MAIDEN NAME <b>Fredericka Ossentrink</b>		14. NAME OF HUSBAND OR WIFE <b>Louis Poese</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Charles McConnell, St. Charles, Mo.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Liver</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
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) <b>1561</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Jan. 16, 1953</b>		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 <b>Feb. 11, 1952</b> , to <b>Jan. 17, 1953</b> , that I last saw the deceased alive on <b>Jan. 16, 1953</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>L.R. McIntire M.D.</b>				23b. ADDRESS <b>St. Charles, Mo.</b>		23c. DATE SIGNED <b>Jan. 19, 1953</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>January 20, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Charles, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>Jan 20 1953</b>		REGISTRAR'S SIGNATURE <b>Francie Kammeth</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Huchmann - Rowe, St. Charles, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

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MAR 25 1937

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 Clarence M. Bills

Licensed Embalmer No. 4375

P. O. Address St. Charles, 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.