No. 300
10-48

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10065

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2402

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. LOUIS CITY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY

c. CITY OR TOWN ST. LOUIS
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒ 2219

STREET ADDRESS (If rural, give location) 21 1321a Hogan

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) c. (Last) POFF

4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 18, 1955

5. SEX MALE 0
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER 2
8. DATE OF BIRTH JAN. 7, 1870
9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) INDIANA 1
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME JOHN
13b. MOTHER'S MAIDEN NAME RACHEL
14. NAME OF HUSBAND OR WIFE

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.
17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD ADDRESS

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) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Post of amputation of Leg
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

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? 4200

22. *I hereby certify that I attended the deceased from* 2-7-55, 19___, *to* 2-18-55, 19___, *that I last saw the deceased alive on* 2-18-55, 19___, *and that death occurred at* 3:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE John T. Leahy (Degree or title) MD 0
23b. ADDRESS 1515 Lafayette Avenue
23c. DATE SIGNED 2-19-55

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 3-31-55
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. MAR 16 1955
REGISTRAR'S SIGNATURE J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service
Manchester Ave.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.