

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028773

STATE FILE NUMBER

Registration District No. 93

Primary Registration District No. _____

Registrar's No. _____

61-65

AMENDED

FILED AUG 21 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dade</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ceder TWP</u> | | c. CITY OR TOWN <u>Lockwood Mo rt2</u> | |
| Length of stay in 1b <u>2yrs</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>14 mi n Lockwood Mo</u> | | d. STREET ADDRESS (If outside, give location) <u>14 mi n. Lockwood Mo.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Washington</u> Last <u>Poe</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 30 1865</u> |
| 9. AGE (last birthday) <u>95</u> | | IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> | IF UNDER 24 HR Hours <u>16</u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmig</u> | 11. BIRTHPLACE (City and state or country) <u>Elkton Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Unknown</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Poe</u> | | 14. NAME OF HUSBAND OR WIFE <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Edgar Poe Lockwood Mo rt2</u> | | Address <u>Lockwood Mo rt2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> | | | <u>years</u> |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY _____ STATE _____ |
| 21. I attended the deceased from <u>7-7-61</u> , to <u>8-16-61</u> and last saw her/him alive on <u>8-14-61</u> . Death occurred at <u>6:00A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Elmer Taylor M.D.</u> | | 22b. ADDRESS <u>Lockwood, Mo.</u> | 22c. DATE SIGNED <u>8-16-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug 18 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Krutsinger</u> | 23d. LOCATION (City, town, or county) (State) <u>Wheatland Mo</u> |
| 24. FUNERAL DIRECTOR <u>Hathaway Funeral Home Wheatland Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>8/16/61</u> | 26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u> |

NOV 12 1964

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 _____
Signature of Student Embalmer

Signed W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield, Ohio

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.