

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003298

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 26

FILED JAN 31 1962

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>2 Weeks</u>	c. CITY OR TOWN <u>St. Charles</u> Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <u>322 S. 6th. St.</u> Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. NAME OF DECEASED First Middle Last <u>William H. Poes Sr.</u>			4. DATE OF DEATH Month Day Year <u>January 21, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1881</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fr. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>St. Charles County, Mo. USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Ernest Poes</u>	13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Remer</u>
14. NAME OF HUSBAND OR WIFE <u>Alma Leinkuehler Poes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> No	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT Address <u>Mrs. Alma Poes, St. Charles, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cerebral Vasc. Dis.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to terminal disease condition given in PART I (a) <u>Comminuted Fracture of Left Femur (antitrochanteric)</u> PART VII. 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 Month, Day, Year <u>6:30 p.m.</u>		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>March 1957</u> to <u>1/21/62</u> and last saw him alive on <u>1/20/62</u> Death occurred at <u>6:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul H. Luther MD</u> (Degree or title)		22b. ADDRESS <u>St. Charles, Mo</u>	22c. DATE SIGNED <u>1-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/24/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orchard Farm Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 24-62</u>	26. REGISTRAR'S SIGNATURE <u>Margaret Wilson</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 John C. Smith

Licensed Embalmer No. 5145

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