

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36549**

Registration District No. 11

Primary Registration District No. 5044

Registrar's No. 59

**1. PLACE OF DEATH:**

(a) County BARRY MO

(b) City or town Washburn *Washburn*

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community life years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Barry

(c) City or town Washburn (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** CLAUDE POE

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Oma Poe

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Aug. 3, 1895

(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>50</u>	<u>2</u>	<u>1</u>	hr. _____ min.

9. Birthplace Garfield Ark.

(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business running sawmill

12. Name Harve Poe

13. Birthplace Ind.

(City, town, or county) (State or foreign country)

14. Maiden name Frances Gilisp

(City, town, or county) (State or foreign country)

15. Birthplace Ind.

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Oma Poe

(b) Address Washburn Mo.

17. (a) burial (b) Date thereof 10/7/45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hickman Cem.

18. (a) Signature of funeral director W. Hickman

(b) Address Cassville, Mo.

19. (a) Oct 13-1945 (b) Grace Williams

(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 10 4  
year 1945 hour 12 minute 20 A. M.

21. I hereby certify that I attended the deceased from Oct. 4  
1945 to Oct. 4 1945

that I last saw him alive on Oct 4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Crushing injury to chest

Due to being run over by a motor vehicle

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

*1700-8*

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Oct. 3, 1945

(c) Where did injury occur? Washburn Barry, Mo.

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

on public highway No. 37

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury vehicle

23. Signature Grace Williams (M. D. \_\_\_\_\_)

Address Cassville Mo. Date signed 10-11-45

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

500

RECEIVED

District Health Officer No. 6,

District File Number 1145-1137

Date Filed NOV 17 1945

**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed E. M. Jones

Licensed Embalmer No. 3453

P. O. Address Cassville, 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.**