MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 8 1959

59-041455

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 452

AMENDED

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre
Length of stay in 1b: **
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Francois
c. CITY OR TOWN Bonne Terre
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 414 Jackson
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First * MARTHA Middle PEARL Last POSTON *

4. DATE OF DEATH: Month Nov. Day 27, Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 3-28-1882

9. AGE (last birthday): 77

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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: **

11. BIRTHPLACE (City and state or country): Bonne Terre, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Goff Poston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) **

16. SOCIAL SECURITY NO.: **

17. INFORMANT: Ben Morris Address: Rt. 1 Bonne Terre, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Senility
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Anemia due to unknown Cause.

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [X] No [ ] Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 1958, to Nov 26, 1959 and last saw her alive on Nov. 26, 1959
Death occurred at 2:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. A. Huckstep (Degree or title) M.D.

22b. ADDRESS: Farmington, MO

22c. DATE SIGNED: 11/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 29, 1959

23c. NAME OF CEMETERY OR CREMATORY: St. Fran. Mem. Park

23d. LOCATION (City, town, or county) (State): Bonne Terre, Mo.

24. FUNERAL DIRECTOR: C. J. Boyer & Son ADDRESS: Bonne Terre, Mo

25. DATE RECD. BY LOCAL REG.: Nov. 30, 1959

26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

HUCKSTEP
HED. ARTS. BLDG

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Destrop, T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.