S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38704

FILED NOV 29 1944

Registration District No. 3179 Primary Registration District No. 3059 Registrar's No. 204

1. **PLACE OF DEATH:**
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days) lifetime

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County St Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. 33 W. Main
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mahala Elizabeth Poston
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Dr C P Poston
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 27 (Day) 1856 (Year)

8. AGE: Years 88 Months 9. Days 9. If less than one day hr. min.

9. Birthplace St Francois (City, town, or county) Mo (State or foreign country)
10. Usual occupation housewife.
11. Industry or business

MOTHER FATHER
12. Name Rose Cunningham
13. Birthplace St Francois (City, town, or county) Mo (State or foreign country)
14. Maiden name Nancy Williams
15. Birthplace Frankfort (City, town, or county) Ky (State or foreign country)

16. (a) Informant H P Poston
(b) Address Bonne Terre Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Bonne Terre
18. (a) Signature of funeral director Benham & Son Co.
(b) Address Bonne Terre Mo.
19. (a) Oct 30 1944 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 18
year 44, hour minute 2 A. M.
21. I hereby certify that I attended the deceased from Dec 20-43, 19 to Oct. 18, 19 44
that I last saw her alive on Oct. 18, 19 44
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	24 hrs
Due to	
Due to Myo cardial failure	
Other conditions. Chr. Nephritis (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work (Specify) Means of injury

23. Signature H. P. Poston M.D. (M. D. or other)
Address Bonne Terre Mo Date signed 10/19/44

1373 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 1144-4459

Date Filed 11-22-44

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 [redacted], Registered Apprentice No. [redacted], working under my personal supervision.

Signed C J Claywell

Licensed Embalmer No. 3706

P. O. Address Donne Seire 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.