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

FILED OCT 12 1945

State File No. 31373

Registration District No. 316 — Primary Registration District No. 3059 — Registrar's No. 144

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: 44 Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. 44 Park
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ARTIMISSA EMMA POSTON
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William Garon Poston
6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased June (Month) 10 (Day) 1865 (Year)

8. AGE: Years 80 | Months 0 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Batesville (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Retired

11. Industry or business .....

MOTHER / FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Kargah Brudy
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Leota Poston
(b) Address Park St Bonne Terre Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17 1945 (Month) (Day) (Year)
(c) Place: burial or cremation B. J. Cemetery

18. (a) Signature of funeral director Benham Funeral Co
(b) Address 313 Benham Bonne Terre Mo

19. (a) 9-C-45 T (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 14th year 1945 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from 1-7, 1945 to 6-14, 1945 that I last saw her alive on June 10 - 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Apoplexy. Thrombosis	4 days
Due to: Cerebral Arterio Sclerosis	1 yr
Due to: Hypertension disease	3 years
Other conditions (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? (e) Means of injury .....

23. Signature Geo. L. Wolters (M. D. or other)
Address Farmington Mo Date signed 9-6-45

1397

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 1045-120

Date Filed 10-9-45

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 _____

Licensed Embalmer No. 3706

P. O. Address Boone Iowa

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.