

Registration District No. **837**

Primary Registration District No. **4508**

1. PLACE OF DEATH:

(a) County **Stoddard**
(b) City or town **Bloomfield, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Years** years, months or days

3. (a) PRINT FULL NAME **ETTA MAY POUTHIES**

3. (b) If veteran, name war _____ (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **August Pouthies** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb. 27, 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 11 11 hr. min.

9. Birthplace **Shawneetown, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **James Franklin McClard**
13. Birthplace _____ Mo.
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Jane Hill**
15. Birthplace **Not known** 9 Not known
(City, town, or county) (State or foreign country)

16. (a) Informant **Marie McClard**
(b) Address **Bloomfield, Mo. Rural**

17. (a) **Burial** (b) Date thereof **Feb. 9-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bloomfield, Mo.**

18. (a) Signature of funeral director **Chiles Und. Co.**
(b) Address **Bloomfield, Mo.**

19. (a) **Feb 17, 1942** (b) **Sail Clewore**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard** / 03
(c) City or town **Bloomfield** / 2
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **8th**
year **1942** hour **3:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **FEB. 7**, 19**42**, to **FEB. 8**, 19**42**
that I last saw h. **OR** alive on **FEB. 8**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL HEMORRHAGE** Duration **2 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **830**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **R. S. Davis** (M. D. or other)
Address **BLOOMFIELD** Date signed **2-9-42**

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

3
0
2

RECEIVED

District Health Office No. 2,

District File Number 342/343

Date Filed 3/10/42

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 Deceased was not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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.