

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED FEB 13 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3187

Registration District No. 409

Primary Registration District No. 4363

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Keyston

(b) City or town Neosho

(c) Name of hospital or institution: Dale Bowman Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3 Days
(Specify whether In this community years, months or days) 2 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

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

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME LOLA GLADYS ROGUE

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Ray Pogue

6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased July 24 1917
(Month) (Day) (Year)

8. AGE: Years 20 Months 5 Days 8

If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business ✓ 0

MOTHER FATHER { 12. Name Joe Harry 0

13. Birthplace McDonald Co. Mo 0
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Worth Cuthbert

15. Birthplace McDonald Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ray Pogue

(b) Address Goodman Mo

17. (a) Goodman Mo (b) Date thereof Jan 4 1940
(Burial, ~~cremation~~) (Month) (Day) (Year)

(c) Place: burial or cremation Goodman Mo

18. (a) Signature of funeral director Chas W. Williams

(b) Address Goodman Mo

19. (a) 1-4-40 (b) Orval R. Salum
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1940 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from March, 1939, to Jan. 3, 1940;
that I last saw her... alive on Jan. 3, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death General peritonitis Duration

Due to Ectopic pregnancy

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Ectopic pregnancy

Of operations _____

Of autopsy General peritonitis

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? 5:30 (Specify type of place) (e) Means of injury ✓

Signature Donald Lake (M. D. or other) ✓

Address Neosho, Mo. Date signed 1/4

RECEIVED

District Health Officer No. 6,

District File Number: 240 - 430

Date Filed FEB 13 1940

142

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.....

Marcellan Williams, Registered Apprentice No. 234

working under my personal supervision.

Signed J. B. [Signature]

Licensed Embalmer No. 2689

P. O. Address Neon, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *3187*

Registration District No.

Primary Registration District No.

Registrar's No. *4*

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

1. PLACE OF DEATH:

(a) County *Newton*
(b) City or town *Nesha*
(c) Name of hospital or institution: *Dale - Bowman Hosp.*
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

3. (a) PRINT FULL NAME

Lola G. Pogue

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 *m*

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) *1-4-40* (b) *Enal R. Sal... M.D.* (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan.* day *3-40* year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death *Gen. Peritonitis* (Duration)

Due to *Ectopic pregnancy*

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

No abortion.
Major findings: *Wideman opened, Ectopic removed Dec. 29, 1939.*
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) (c) Means of injury.....

23. Signature *Enal Sal...* (M. D. or other).....

Address *Nesha Mo.* Date signed.....

SUPPLEMENTARY

S-3187