

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 922

Registration District No. 498

Primary Registration District No. 5663

1. PLACE OF DEATH:

(a) County LINN  
(b) City or town RURAL Bucklin township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 70 years  
years, months or days

3. (a) PRINT FULL NAME Thomas ALBERT Logue

8. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Sept 4 1856  
(Month) (Day) (Year)

8. AGE: Years 84 Months 9 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Thomas Logue  
18. Birthplace Penn  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Fritz  
15. Birthplace Penn  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature T. J. Logue

(b) Address Marcelline Mo

17. (a) Burial (b) Date thereof June 7-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director James M. Sengula

(b) Address Marcelline Mo

19. (a) 6-7-1941 (b) J. A. Bartwell  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINN  
(c) City or town RURAL-Bucklin township  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5  
year 1941 hour 4 minute 20 AM

21. I hereby certify that I attended the deceased from July  
1938 to June 5 1941;  
that I last saw him alive on June 4 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute heart failure Duration 5 da

Due to Aortic dilatation 5 yrs

Due to Essential hypertension 10 yrs

Other conditions 102  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. A. Bartwell (M. D. or other) MD  
Address Marcelline Mo Date signed 6/8/41

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

REV. 5-17-39 I X1931

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.

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**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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Merced, 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. 25512  
Registrar's No. ....

Registration District No. 498

Primary Registration District No. 5663

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

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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Thomas A Logue  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day.....  
year 1941 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced y  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Sept 4 1858  
(Month) (Day) (Year)

Due to acute heart failure  
arterio dilatation  
Due to Essential hypertension  
not due to syphilis  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....

8. AGE: Years 84 Months 9 Days 15 If less than one day 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.....  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....  
19. (a)..... (b).....  
(Date received local registrar) (Registrar's signature)

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 W.B. Portman (M. D. or other) M.D.  
Address Marceline Date signed 1/19/42

Duration  
15 years  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-25512