

LED JUN 7 1943 274

Registration District No. 274 Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County PETTIS  
(b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BOTHWELL HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 DAYS  
(Specify whether years, months or days) 3 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BENTON  
(c) City or town LINCOLN MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location) 0  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME MARGARET POAGUE

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 W  
6. (b) Name of husband or wife JOHN W. 6. (c) Age of husband or wife if alive 3 years  
7. Birth date of deceased 11 3 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 6 21 hr. min.

9. Birthplace CLARION Co. PENN. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN M. RINARD  
13. Birthplace CLARION Co. PENN. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name ISABELLE NEAL  
15. Birthplace CLARION Co. PENN. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant J. R. POAGUE  
(b) Address LINCOLN MO

17. (a) BURIAL (b) Date thereof 5 28 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation SUNNYSIDE CEMETERY

18. (a) Signature of funeral director Gillespie  
(b) Address SEDALIA MO

19. (a) 5/27/43 (b) ..... (Registrar's signature)  
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 24<sup>th</sup>  
year 1943 hour 1:30 minute 0 M.

21. I hereby certify that I attended the deceased from 5/22 1943, to 5/24 1943  
that I last saw her alive on 5/24 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Shock from fracture of leg  
Due to fall & fracture of thigh 20y.  
Due to

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

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident 008  
(b) Date of occurrence 5/22 43  
(c) Where did injury occur? Lincoln Benton MO  
(City or town) (County) (State)  
Her Home  
(Specify type of place)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? yes (e) Means of injury fall at  
23. Signature D. P. Dyer (M. D. or other)  
Address Sedalia Mo 0 Date signed 5/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-3-43.....

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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 L. E. Boulcher.....

Licensed Embalmer No. 3867.....

P. O. Address Bedford.....

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 172

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bothwell Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)  
In this community 3 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

Margaret Poague

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 W

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

7. Birth date of deceased Nov 3  
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Penn  
(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 \_\_\_\_\_ (State or foreign country)

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) 5-27-43 (b) (Mrs Anna Berger)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 4 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. (Immediate cause of death) \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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)  
(b) 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

S-18679