

FILED MAR 15 1945

Registration District No. 300

Primary Registration District No. 6029

Registrar's No. 3

1. PLACE OF DEATH: *Reynolds*

(a) County *Reynolds*

(b) City or town *Rural (Arlington Mo)*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *Logan Hosp*

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community *life* _____ (Specify whether)

years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Reynolds*

(c) City or town *Arlington Rural*
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME *RHOBA JANE 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 *Widow*

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

7. Birth date of deceased *NOV 19 1860*
(Month) (Day) (Year)

8. AGE: Years *84* Months *3* Days *9* If less than one day _____ hr. _____ min.

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

10. Usual occupation *housekeeper*

11. Industry or business _____

MOTHER FATHER { 12. Name *amb*

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 *Mrs Simon Pogue*

(b) Address *Arlington Mo.*

17. (a) *Burial* (b) Date thereof *3-4-45*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Arlington Cemetery*

18. (a) Signature of funeral director *Walter A. Funchell*

(b) Address *Van Buren*

19. (a) *3-5-1945* (b) *Essie Evans*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* day *1* year *1945* hour *1* minute *10* P. M.

21. I hereby certify that I attended the deceased from *Feb 8* 1945 to *March 1* 1945 and that death occurred on the date and hour stated above. *Feb 15* 1945

Immediate cause of death *Influenza complicated with Broncho Pneumonia* Duration *30 days*

Due to *old age complications*

Due to _____

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

Major findings: Of operations *336*

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 *A. F. Buzz* (M. D. or other) *MD*

Address *Arlington Mo* Date signed *3-2-45*

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

RECEIVED

District Health Officer No. 5,

District File Number

345145

Date Filed

3-14-45

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 no Emb.

Registered Apprentice No.

working under my personal supervision.

Signed

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.