

FILED OCT 29 1945

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

Registration District No. 21

Primary Registration District No. 5460

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Greene  
 (b) City or town Springfield "RURAL"  
 (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 \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Greene  
 (c) City or town Rogersville, Rural Clay T. S.  
 (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 LESTER R. POGUE

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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 12 21 1928  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
16 7 15 hr. min.

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

10. Usual occupation Employee Kraft Cheese Company.

11. Industry or business \_\_\_\_\_

12. Name W. H. Pogue

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

14. Maiden name Nancy Williams

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

16. (a) Informant W. H. Pogue

(b) Address Rogersville Missouri. RFD#2

17. (a) Burial (b) Date thereof 8 18 45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Chapel Cemetery

18. (a) Signature of funeral director Kelley-Ferrell

(b) Address Rogersville Missouri

19. (a) 8/29/45 (b) Mr. M. M. Smith  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15,  
 year 1945 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from  
Dr. Physician 19 no attendance 19 \_\_\_\_\_  
 that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture skull & crushed chest  
 Due to RR crossing accident

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) Accident  
 (b) Date of occurrence Aug 15, 1945  
 (c) Where did injury occur? Greene  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Grade crossing Public road  
 While at work? Yes (Specify type of place) (e) Means of injury RR train  
 23. Signature James C. Stone (M. D. or other) \_\_\_\_\_  
 Address Springfield, Mo Date signed 8-21-45



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

RECEIVED

Greene County Health Office,

County File Number... 45-10-76

Date Filed 10-26-75

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 H. H. Kelley

Licensed Embalmer No. 3334

P. O. Address Superior Ave

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 402  
Registrar's No. \_\_\_\_\_

Registration District No. 125 Primary Registration District No. 5460

1. PLACE OF DEATH:

(a) County Shelby - Clay  
(b) City or town Springfield Rural  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Lester R. Pogue

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Dec 2 1902  
(Month) (Day) (Year)

8. AGE: Years 16 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 \_\_\_\_\_

MOTHER FATHER { 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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

Was riding my car that crashed into trow at railroad crossing east of Springfield  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: No attending physician as witness apparently killed  
Of operations \_\_\_\_\_  
Of cause \_\_\_\_\_

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 Murray C. Stange (M.D. or other) \_\_\_\_\_  
Address Prater Date signed 2/21/48

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

SUPPLEMENTARY

MAR 7 1989

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