

FILED DEC 12 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 245

Primary Registration District No. 3047

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Neosho, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sales Memorial Hospital
(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 Lawrence 55
(c) City or town Aurora, Mo.
(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 Grover Cleve Pogue

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

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

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

7. Birth date of deceased December 20 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 1 If less than one day hr. min.

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

10. Usual occupation School Teacher

11. Industry or business " " " "

12. Name William M. Pogue

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

14. Maiden name Marguret J. Gulp

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

16. (a) Informant Etha Pogue

(b) Address Aurora, Missouri

17. (a) Burial (b) Date thereof Nov. 23 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stella, Mo.

18. (a) Signature of funeral director V. D. Meyers

(b) Address Peace City, Mo.

19. (a) Dec. 1, 1945 (b) Melvin C. Bowman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21
year 1945 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-1-
1945 to 11-21-45
that I last saw him alive on Nov 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia of right chest - and pericardial effusion Duration
Resuscitation
Due to Injury from phlebotomy
left leg, following bilateral
sternal Ribs about 2 1/2 months ago

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy None

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?

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

23. Signature Melvin C. Bowman (M. D. or other) M.D.
Address Neosho, Mo. Date signed 11-26-45

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

MOTHER FATHER

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.

RECEIVED DEC 8 1945
District Health Officer No.....
District File Number 1145-224
Date Filed DEC 10 1945

Signed Victor O. Menniger
Licensed Embalmer No. 3872
P. O. Address Peru City, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 102

Registration District No. 245

Primary Registration District No. 3047

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Neerks
(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 Shover C. 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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 20 1945
(Month) (Day) (Year)

8. AGE: Years 52 Months 1 Days 10
(If less than one day)

hr. 10 min. 30

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)

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 _____ 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 _____

Due to _____

Due to _____

Other conditions labor right side
(Include pregnancy within 3 months preceding death)

Major findings: **SUPPLEMENTARY INFORMATION REQUESTED**

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 _____ (M. D. or other) _____

Address _____ Date signed 11-24-45

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

SUPPLEMENTARY

38064