

FILED JAN 9 1947

Registration District No. **324**

Primary Registration District No. **6093**

Registrar's No. **213**

1. PLACE OF DEATH:  
(a) County **Saline**  
(b) City or town **Marshall township**  
(c) Name of hospital or institution: **B.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **COOPER** **27**  
(c) City or town **Boonville**  
(If outside city or town limits, write "RURAL") **1**  
(d) Street No. \_\_\_\_\_ (If rural, give location) **2**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **1**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Lewis Anderson Pogue Jr.**  
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 alive \_\_\_\_\_ years  
7. Birth date of deceased **December 17th, 1926**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**20 0 9** hr. min.

9. Birthplace **Boonville Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Taxi driver**

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

MOTHER FATHER { 12. Name **Lewis Anderson Pogue**  
13. Birthplace **Cooper County Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Eliza Ann Chenault**  
15. Birthplace **Cooper County Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Lewis A. Pogue**  
(b) Address **Boonville, Missouri**

17. (a) **Burial** (b) Date thereof **Dec. 29, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Boonville, Mo.**  
18. (a) Signature of funeral director **Charles Pogue**  
(b) Address **Marshall, Mo.**

19. (a) **12-28-46** (b) **Mrs J.O. Westbrock**  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **Dec** day **20** year **1946** hour **in afternoon** M.  
21. I hereby certify that I attended the deceased from **inquest - held** 19 **46**  
that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Homicide**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **Yes 166**

22. If death was due to external causes, fill in the following:  
(c) Accident, suicide, or homicide (specify) **Homicide**  
(b) Date of occurrence **Dec. 20, 1946**

(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? **No**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
Signature **W. H. Lawless Corona** (M: D. or other) **3**  
Address **Marshall Mo.** Date signed **12-20-46**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-4-47

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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 RW Campbell Jr

Licensed Embalmer No. 3469

P. O. Address Marshall

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Jan  
Registrar's No. 213

Registration District No. 324 Primary Registration District No. 6093

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town 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) (Specify whether

3. (a) PRINT FULL NAME

Lewis A. Pogue Jr

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

7. Birth date of deceased Dec 17 (Month) (Day) (Year)

8. AGE: Years 20 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER { 12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name (City, town, or county) (State or foreign country)  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12-28-46 (Date received local registrar) (b) Mo T. Oelschlaeger (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 12 Year 1946 hour minute M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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)

(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 \_\_\_\_\_

SUPPLEMENTARY

43187