No. 300
10-48

FILED JUN 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16559

BIRTH NO. _____ REG. DIST. NO. 193 PRIMARY REG. DIST. NO. 5709 Registrar's No. 25

1. PLACE OF DEATH
a. COUNTY McDonald
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural- Buffalo
c. LENGTH OF STAY (in this place) 47 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 1 Goodman

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY McDonald
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural- Buffalo
d. STREET ADDRESS (If rural, give location) Route 1 Goodman

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) MADISON
c. (Last) POGUE

4. DATE OF DEATH (Month) (Day) (Year) April 24, 1949

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 21, 1874
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months 2 Days 3 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) McDonald Co., Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Terrell James Pogue
13b. MOTHER'S MAIDEN NAME Sarah Crawshaw
14. NAME OF HUSBAND OR WIFE Patsy La Fon Pogue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rt. 1 Goodman, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — 6 mo, Mo

ANTECEDENT CAUSES — DUE TO (b) Arteriosclerosis — 1 yr

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — 331X

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from June 1, 1948, to Apr 24, 1949, that I last saw the deceased alive on Apr. 17, 1949, and that death occurred at 4:40A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) S. B. Buck M.D.
23b. ADDRESS Anderson, Mo.
23c. DATE SIGNED 4/27/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE April 25, 1949
24c. NAME OF CEMETERY OR CREMATORY Banner Nazarene Cemetery
24d. LOCATION (City, town, or county) (State) McDonald Co., Missouri

DATE REC'D BY LOCAL REG. 5-10-49
REGISTRAR'S SIGNATURE Mrs. Fred W. Smith
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodman, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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.