

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6034

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE, (Where deceased lived, if institution; residence before admission). a. STATE Missouri b. COUNTY Jefferson MO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Crystal City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) W.R. = 803 Burgess	
3. NAME OF DECEASED a. (First) Thomas b. (Middle) A. c. (Last) Pogue			4. DATE OF DEATH (Month) (Day) (Year) July 8 1949
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec 28 1869
9. AGE (In years last birthday) 79		10a. USUAL OCCUPATION (Give kind of work done during present working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY P.P.D. Co.
11. BIRTHPLACE (State or foreign country) Testerville MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John L. Payne		13b. MOTHER'S MAIDEN NAME Jamna Wilson	
14. NAME OF HUSBAND OR WIFE Mrs. Shas Pogue (Sarah)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Shas Pogue	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic CardioVasc. dis. INTERVAL BETWEEN ONSET AND DEATH  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gangrene Rt. leg.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) 9300		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 4521	
22. I hereby certify that I attended the deceased from 7-1, 1949, to 7-8, 1949, that I last saw the deceased alive on 7-8, 1949, and that death occurred at 10 A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Thomas H. Boett M.D.		23b. ADDRESS St. Johns Hospital	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-11-49	
24c. NAME OF CEMETERY OR CREMATORY Roselawn Mem. Pk.		24d. LOCATION (City, town, or county) (State) Crystal City MO	
DATE REC'D BY LOCAL REG. JUL 11 1949		REGISTRAR'S SIGNATURE J. B. Lassiter	
25. FUNERAL DIRECTOR'S SIGNATURE Gentry P. Palitte		ADDRESS Crystal City MO	

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

over 17 y

**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 Eleanore Prince .....

Signed .....  
Student Embalmer

Licensed Embalmer No. 3493 .....

P. O. Address Festus 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.