

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41870

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

FILED DEC 23 1949

BIRTH NO. _____		REG. DIST. NO. <u>243</u>		PRIMARY REG. DIST. NO. <u>5831</u>		Registrar's No. <u>37</u>				
1. PLACE OF DEATH a. COUNTY <u>Newton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Newton</u>						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Franklin</u>		c. LENGTH OF STAY (in this place) <u>7m07dy</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Franklin</u>						
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>(Home) 1 mile n. Stella Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>1 mile N. of Stella Mo.</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>Connie</u> b. (Middle) <u>Joan</u> c. (Last) <u>Pogue</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 / 25 49</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>(Child) (I)</u>		8. DATE OF BIRTH <u>2/28/1949</u>				
9. AGE (In years last birthday) <u>7</u>		# UNDER 1 YEAR Months <u>7</u>		# UNDER 1 YEAR Days <u>7</u>		# UNDER 1 YEAR Hours <u></u> Mins. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Missouri</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>Leon Pogue</u>		13b. MOTHER'S MAIDEN NAME <u>Nadine Ward</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Leon Pogue</u> ADDRESS <u>Stella Mo.</u>						
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Pneumonia - bronchial</u>  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.  19a. DATE OF OPERATION _____					19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input 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) _____						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____						
22. I hereby certify that I attended the deceased from <u>10-24</u> , 19 <u>49</u> , to <u>10-25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>49</u> , and that death occurred at <u>4 p. m.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>C. Cardwell</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>Stella, Mo.</u>			23c. DATE SIGNED <u>12-12-49</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/27/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		24d. LOCATION (City, town, or county) (State) <u>Stella Mo.</u>				
DATE REC'D BY LOCAL REG. <u>12-16-1949</u>		REGISTRAR'S SIGNATURE <u>Alpha Dyer</u> <u>369</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Morris Pogue</u> ADDRESS <u>Wheaton Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. MEADON COUNTY HEALTH DEPT  
District File Number 1249-235  
Date Filed DEC 21 1949

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 \_\_\_\_\_

..... James Kenyth Duncan ..... Student Embalmer No. 308  
working under my personal supervision.

Signed Kenyth Duncan  
Student Embalmer

Signed Wm Morris Coz  
Licensed Embalmer No. 3442

P. O. Address Wheaton Missouri

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.