

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34993

State File No. ....

No. 300  
10.48

FILED NOV 10 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 287 PRIMARY REG. DIST. NO. 6026 Registrar's No. 27

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Reynolds</u>                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <u>MO</u> b. COUNTY <u>Reynolds</u> |   |
| b. CITY (If outside of rural limits of R.U.P. and give township) <u>Carroll Twp</u> |  | c. CITY OR TOWN <u>CARROL TWP</u>  | d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>2 yrs</u>                                      |  | e. STREET ADDRESS (If rural, give location) <u>0900</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home of SAUGHAR MAS ADA MARTIN</u>       |  |  |   |

|  |                           |   |  |   |  |
|--|---------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>SARAH</u> b. (Middle) <u>Eller</u> c. (Last) <u>Pogue</u> |                           |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct 28, 54</u>         |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>JAN 19 1881</u>                                | 9. AGE (In years last birthday) <u>73</u> | 10. IF UNDER 1 YEAR Months <u>73</u> Days <u>9</u> Hours <u>9</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>                            | 11. BIRTHPLACE (City and State or Foreign Country) <u>Kentucky</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 13a. FATHER'S NAME <u>Z. W. Flowers</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Louisa Howell</u> |  | 14. NAME OF HUSBAND OR WIFE <u>JAMES H. Pogue</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u> |  | 16. SOCIAL SECURITY NO. <u>None</u>            |  | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Thomas F. Pogue 9612 Balboa Drive St. Louis, Mo</u> |  |

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hrs</u><br><u>3 yrs</u><br><u>1 yr</u> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) <u>Arteriosclerosis</u> |  |  |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |

|  |   |  |
|--|---|--|
| 19a. DATE OF OPERATION                                 | 19b. MAJOR FINDINGS OF OPERATION <u>331X</u>  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)                                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from Oct 27, 1954 to Oct 28, 1954, that I last saw the deceased alive on Oct 27, 1954, and that death occurred at 7:15 AM, from the causes and on the date stated above.

|   |   |   |   |                                 |
|---|---|---|---|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>E. M. Anderson M.D.</u> |   | 23b. ADDRESS <u>Leetonville MO</u>  |   | 23c. DATE SIGNED <u>11/6/54</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>     | 24b. DATE <u>Oct. 29, 54</u>                    | 24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>                         | 24d. LOCATION (City, town, or county) (State) <u>Ellington (rural) MO</u> |                                 |
| DATE REC'D BY LOCAL REG. <u>11/11/54</u>                    | REGISTRAR'S SIGNATURE <u>E. M. Anderson</u> 275 | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Chas S. Smith Ellington, Mo</u> |   |                                 |

(Licensed Embalmer's Statement on Reverse Side)

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

0900

Received 11-8-54  
Reynolds County Health  
File No. 1154 - 56

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Chas. S. Penick*.....

Licensed Embalmer No. 457.....

P. O. Address *Ellington, Tenn.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.