

FILED APR 4 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8832**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **87**

1. PLACE OF DEATH a. COUNTY Marion.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Monroe	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal, Missouri		c. CITY OR TOWN R.F.D. Perry, Mo.	
c. LENGTH OF STAY (In this place) 8 Days		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital		e. STREET ADDRESS (If rural, give location) Rural (Jefferson Township)	

3. NAME OF DECEASED (Type or Print) a. (First) Fredrick b. (Middle) William c. (Last) Poage.			4. DATE OF DEATH (Month) (Day) (Year) March 20, 1955.	
--	--	--	---	--

5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 2, 1888		9. AGE (In years last birthday) 66 # UNDER 1 YEAR 8 MONTHS # UNDER 2 WKS. 18 HOURS MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm			11. BIRTHPLACE (City and State or Foreign Country) Monroe Co, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME James H. Poage		13b. MOTHER'S MAIDEN NAME Sarah E. Hickman.		14. NAME OF HUSBAND OR WIFE Beatrice Poage	
--	--	--	--	---	--

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

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, athermia, 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) Embolism cerebral artery, left		ANTECEDENT CAUSES Right hemiplegia DUE TO (b)				6 days	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Terminal pneumonia DUE TO (c)						6 days	
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 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 type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
---	--	--	--	--	--	-----------------------------------	--

22. I hereby certify that I attended the deceased from 1-22-55, 19, to 3-19-55, 19, that I last saw the deceased alive on 3-19-55, 19, and that death occurred at 6:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.		23b. ADDRESS Hannibal, Missouri.		23c. DATE SIGNED 3-21-55	
---	--	---	--	---	--

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-22-1955		24c. NAME OF CEMETERY OR CREMATORY Southfork Cemetery		24d. LOCATION (City, town, or county) (State) Monroe Co, Missouri.	
---	--	--------------------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. 3-27-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Perry, Mo.	
---	--	--	--	---	--	-------------------------------------	--

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED APR 1 1955
MARION CO. HEALTH DEPT.
DATE FILED APR 1 1955

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..... *Clyde C. W. Perry*

Licensed Embalmer No..... 3820

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