

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16180

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 170

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NEWTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN COLUMBIA Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN STARK CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ELLIS FISCHER Length of stay in 1b 2 hrs.		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PRICE, WILLIAM POGUE			4. DATE OF DEATH Month Day Year 5-13-1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1896
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	11. BIRTHPLACE (City and state or country) NEWTON COUNTY, Mo.
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 country) NEWTON COUNTY, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN POGUE	
14. MOTHER'S MAIDEN NAME CORDELIA EAST		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Fistulae in ans, multiple DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 574x			INTERVAL BETWEEN ONSET AND DEATH 3 wks Several years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg.; etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 5-13-57 to 5-13-57 and last saw her him alive on 5-13-57 Death occurred at 9:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. E. Johnson, M.D.		22b. ADDRESS Columbia, Mo.	
22c. DATE SIGNED 5-13-57		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE 5/15/1957		23c. NAME OF CEMETERY OR CREMATORY Massachusetts	
23d. LOCATION (City, town, or county) Newton, Missouri		(State)	
24. FUNERAL DIRECTOR ADDRESS Spencer Sparks Columbia		25. DATE RECD. BY LOCAL REG. May 13, 1957	
26. REGISTRAR'S SIGNATURE Mrs. R. E. Palmer			

(Licensed Embolmer's Statement on Reverse Side)

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 *Lyman H. Sprinkle*

Licensed Embalmer No. *401*

P. O. Address *Columbia*

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..