

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 6 1959

59-035668

STATE FILE NUMBER

Registration District No. 198 Primary Registration District No. _____ Registrar's No. 96

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| 1. PLACE OF DEATH a. COUNTY <u>Daviess</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Grand River Twp.</u> Length of stay in lb <u>Most of life</u> | | c. CITY OR TOWN <u>Rural Grand River Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12 Mi. N.E. Gallatin</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>12 Mi. N.E. Gallatin</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>P.</u> Last <u>Pogue</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1959</u> | | |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-9-1884</u> | 9. AGE (last birthday) <u>75</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 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>Own Home</u> | 11. BIRTHPLACE (City and state or country) <u>Daviess Co. Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>John W. Tolbert</u> | 13b. MOTHER'S MAIDEN NAME <u>Ada Poage</u> | 14. NAME OF HUSBAND OR WIFE <u>Forrest Pogue</u> |
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| 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>None</u> | 17. INFORMANT Address <u>Forrest Pogue, Gallatin Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>9 mos.</u> <u>1 1/2 yrs</u> |
| IMMEDIATE CAUSE (a) <u>Thrombosis of Coronary Artery</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio-Vascular-Renal disease</u> | | |
| DUE TO (c) <u>Arterio sclerosis</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) |
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|---|------------------------|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
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|--|--|---|
| 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 |
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21. I attended the deceased from Oct 2, 59 to Oct 31-59 and last saw her/him alive on Oct 30-59
Death occurred at 8:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>F B Bailey</u> | 22b. ADDRESS <u>Jamesport Mo</u> | 22c. DATE SIGNED <u>10-31-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-3-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Gallatin, Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-31-59</u> | 26. REGISTRAR'S SIGNATURE <u>Therese Englehart</u> |
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(Licensed Embalmer's Statement on Reverse Side)

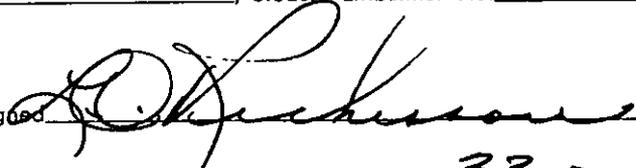
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 5 1980

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 

Licensed Embalmer No. 3302

P. O. Address Greenville

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.