

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001191

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 14<sup>2</sup> Primary Registration District No. 3386 Registrar's No. 2

FILED VS FEB 14 1961

AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

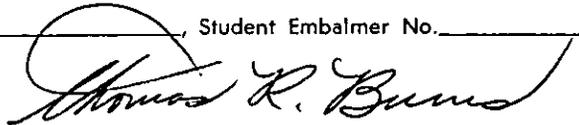
1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u>		Length of stay in 1b <u>15 Hrs.</u>	c. CITY OR TOWN <u>Willow Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>Gen. Delivery</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Claude Wright POAGE</u>			4. DATE OF DEATH Month Day Year <u>Feb. 7, 1961</u>			
5. SEX <u>Male</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>11/11/85</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>2 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Dentist</u>	11. BIRTHPLACE (City and state or country) <u>Paris, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>— Poage</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Calhoun</u>		14. NAME OF HUSBAND OR WIFE <u>Elsie Holland Poage</u>		
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.	17. INFORMANT Address <u>Mrs. Elsie Poage, Willow Spgs., Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cirrhosis of liver</u>				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		
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 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 <u>2/19/60</u> to <u>2/7/61</u> and last saw <sup>her</sup> him alive on <u>2/7/61</u> Death occurred at <u>11:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Amos Coffee, M.D.</u>			22b. ADDRESS <u>Willow Springs, Mo.</u>		22c. DATE SIGNED <u>2/8/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>	23d. LOCATION (City, town, or county) <u>Willow Springs, Mo.</u>			
24. FUNERAL DIRECTOR <u>Burns Funeral Home, Willow Spgs., Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-10-61</u>	26. REGISTRAR'S SIGNATURE <u>Louise Mitchell</u>		

MAR 31 1966

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 Thomas R. Burns

Licensed Embalmer No. 4214

P. O. Address Willow Springs, 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.