

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044293

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. J. WILLIAMS

Primary Registration District No. 2000

Registrar's No. 1242

STATE FILE NUMBER

AMENDED FILED DEC 18 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 2 YRS.	c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2663 E. STANFORD	
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT H. POGGE			4. DATE OF DEATH Month Day Year DEC. 11 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/2/93	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DISTRICT MGR.		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO.	11. BIRTHPLACE (City and state or country) WEST POINT, IOWA		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME HENRY POGGE		13b. MOTHER'S MAIDEN NAME MARY POLENKEMPER		14. NAME OF HUSBAND OR WIFE NEVA NO. POGGE (DEC.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			17. INFORMANT Address MRS. LEO EAST, SPRINGFIELD, MO.		
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>Cerebral Arterio-sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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	
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
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>July 2, 1961</u> to <u>July 19, 1961</u> and last saw her alive on <u>June 9, 1961</u> Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John W. Williams, M.D.</u>			22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>12/12/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 12/12/61	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) RIVERSIDE, IOWA
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. 12-13-61	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	

DEC 18 1961

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 W L McCann

Licensed Embalmer No. 2727

P. O. Address Spfld Ma

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.