

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1284

1. PLACE OF DEATH

County Hickory Registration District No. 364
 Township Stark Primary Registration District No. 4-4-09
 City Preston (No.) St. Ward

File No. 1
 Registered No.
 St. Ward

2. FULL NAME

Nathan K. Poje
 (a) Residence. No. Preston St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

Mary J. Poje

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-21-1843

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	<u>85</u>	<u>5</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) Kentucky
 (STATE OR COUNTRY)

10. NAME OF FATHER John Poje

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kent
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Lightfoot

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kent
 (STATE OR COUNTRY)

14. INFORMANT Olive Poje
 (Address) Preston

15. FILED Jan 10 1929 J. W. Walker
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-6-1929

17. I HEREBY CERTIFY, That I attended deceased from 12-29-1928, to 1-6-1929, 1929
 that I last saw him/her alive on 1-6-1929, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11A
106B
 (duration) 14 yrs. mos. ds.

CONTRIBUTORY Chronic Bronchitis
 (SECONDARY) (duration) 30 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED HA
 IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.
 (Signed) A. S. Johnston, M. D.

(Address) Wheatland Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oliverpoint DATE OF BURIAL Jan. 2 1929

20. UNDERTAKER J. P. Luciey ADDRESS Wheatland Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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